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	10/25/2022

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 a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: October 17, 18, 19, 20, 21, 24, and 25, 2022. Facility number: 013335 Provider number: 155830 AIM number: 201290670 Census Bed Type: SNF/NF: 55 Residential: 40 Total: 95 Census Payor Type: Medicare: 25 Medicaid: 11 Other: 19 Total: 55 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 3, 2022.	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 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 the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of 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.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sean Medsker	Executive Director	11/18/2022

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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	including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record review, the facility failed to ensure residents were	F 0550	1. Resident 54 and 18 suffered no ill effects from the alleged deficient practice. CRCA #4 and CRCA #5 was educated on proper way to	11/18/2022

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	provided dignified dining during 1 of 2 dining observations (Residents 54 and 18). Findings include: During a continuous dining observation, on 10/21/22 from 12:29 p.m. to 12:47 p.m., Certified Resident Care Assistant (CRCA) 4 was observed standing while assisting Residents 54 and 18 to eat lunch. CRCA 4 picked up Resident 54's fork and gave him a bite of food. CRCA 4 put down the fork, walked away from Resident 54's and Resident 18's table, grabbed a clothing protector, placed the clothing protector onto Resident 18, then gave Resident 54 a bite of food, while standing at the residents' table. Then, CRCA 4 gave Resident 18 a drink, as she stood by the resident. CRCA 4 was observed standing while she gave Resident 54 another bite of food, gave Resident 18 a bite of food, gave Resident 54 a bite of food, then gave Resident 18 another bite of food. CRCA 4, while standing, picked up a spoon and dessert cup, gave Resident 54 a bite of dessert, then handed the spoon and dessert cup to CRCA 5. CRCA 5 stood by the residents' dining table as she gave Resident 54 bites of the dessert. On 10/21/22 at 12:52 p.m., the Minimum Data Set (MDS) Consultant indicated staff should not stand but sit down when assisting residents with eating. On 10/24/22 at 9:20 a.m., the Executive Director (ED) indicated, staff should sit down next to the residents when assisting with eating. The facility did not have a policy for staff standing while assisting a resident with eating, but it was the residents' rights to have a dignified dining experience. At that time, the ED provided and identified an undated document as a current		feed residents in the restorative dining room. 2. Residents in the restorative dining room have the potential to be affected by the alleged deficient practice. Residents are observed during restorative dining to ensure staff are sitting next to the resident while feeding them. 3. Nursing staff were educated on proper way to feed residents in the restorative dining room. As a measure of ongoing compliance, executive director (ED) or designee will observe 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months. 4. As a quality measure, the ED 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.	

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	facility policy titled, "Resident Rights Guidelines." The policy indicated, "...PURPOSE...To ensure resident rights are respected and protected and provide an environment in which they can be exercised...PROCEDURES...1. Residents shall not leave their individual personalities or basic human rights behind when they move to a health campus...2. Our residents have a right to...a. Be treated with dignity and respect ...l. Enjoy full use of the campus, including lounges, dining room, activity areas, and outdoor areas in compliance with resident guidelines...." 3.1-3(a)			
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside			

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	and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on interview, observation, and record review, the facility failed to ensure residents were provided showers and shaving as preferred for 2 of 2 residents reviewed for choices (Residents 22 and 110). Findings include: 1. During an interview with Resident 22's spouse, on 10/18/22 at 9:38 a.m., she indicated, Resident 22 had not had a shower in about a week and he preferred to be showered before supper, every other day. The facility had given him occasional showers, late at night. Staff had told Resident 22's spouse, when Resident 22 was admitted, that he would be on the night shower rotation for Mondays, Wednesdays, and Fridays. Resident 22 preferred to be showered in the afternoon before supper, not at 7 p.m. or 8 p.m. at night. Resident 22's record was reviewed on 10/24/22 at 11:27 a.m. The resident was admitted to the facility, on 9/23/22, with diagnoses included, but not limited to, multiple sclerosis (a chronic, typically progressive disease involving damage to the sheaths of nerve cells in the brain and spinal cord, whose symptoms may include numbness, impairment of speech and of muscular coordination, blurred vision, and severe fatigue) and legal blindness. A 5-day admission Minimum Data Set (MDS)	F 0561	1. Residents 22 and 110 suffered no ill effects from the alleged deficient practice. Both residents received showers per their preference and shower schedule has been updated to meet their preference. 2. All facility residents have the potential to be affected by the alleged deficient practice. Current residents have been audited to ensure showers were given at least 2 times a week per their preference. 3. Nursing staff will be educated on giving showers twice a week per their preference and document any refusals. Review for showers during CCM. As a measure of ongoing compliance, director of health services (DHS) or designee will audit 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 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	11/18/2022

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	assessment, dated 9/27/22, indicated Resident 22 was moderately impaired. It was very important to Resident 22 to choose between a tub bath, shower, bed bath, or sponge bath. Resident 22 required extensive assistance of two staff for bed mobility, transfers, dressing, and personal hygiene, and was total dependence of two staff for bathing. A safety care plan, initiated on 9/26/22, indicated the resident required staff assistance to complete activities of daily living (ADL) tasks completely and safely, with the goal of the resident having all ADL needs met safely by staff. On 10/21/22 at 12:11 p.m., the Director of Health Services (DHS) provided Resident 22's shower reports since his admission on 9/23/22. The shower reports showed the resident had received showers on 10/5/22, 10/6/22, 10/7/22, 10/12/22, and 10/17/22. The record lacked documentation the resident had been showered three times a week or had refused showers. The DHS indicated Resident 22 should have been showered at least twice a week. 2. On 10/17/22 at 12:05 p.m., Resident 110 was observed, unshaven with long facial hair, seated in the main dining room eating lunch with his spouse. During an interview with Resident 110's spouse, on 10/17/22 at 12:28 p.m., she indicated, Resident 110 was scheduled for three showers a week, but the resident had not been showered three times a week, since he was admitted. She had asked the staff to shave Resident 110, but he had not been shaven but one time since he was admitted to the facility on 10/4/22. Resident 110 was observed unshaven with long facial hair.		will be reviewed and updated as warranted.	

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	On 10/18/22 at 10:42 a.m., Resident 110 was observed lying in bed with his eyes closed, unshaven with long facial hair. Resident 110's record was reviewed on 10/20/22 at 2:26 p.m. The resident was admitted to the facility on 10/4/22 with diagnoses, included but were not limited to, Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement) and other abnormal involuntary movements. A 5-day admission Minimum Data Set assessment, dated 10/10/22, indicated the resident had a moderate cognitive impairment, was an extensive assistance of two staff for bed mobility, transfer, and personal hygiene, was total dependence of one staff for bathing, and it was very important to Resident 110 to choose between a tub bath, shower, bed bath, or sponge bath. A profile care guide care plan, initiated on 10/5/22, indicated to shower the resident on Monday, Wednesday, and Friday days. A safety care plan, initiated on 10/5/22, indicated the resident required staff assistance to complete ADL (activities of daily living) tasks completely and safely, with the goal of resident will have ADL needs met safely by staff. On 10/21/22 at 12:15 p.m., the Director of Health Services (DHS) indicated provided Resident 110's shower reports since his admission on 10/4/22. The shower reports showed the resident had received showers on 10/5/22 and 10/7/22. The record lacked documentation the resident had been shaven and showered three times a week nor had the resident refused showers. The DHS			

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	indicated Resident 110 should have been showered at least twice a week. On 10/21/22 at 12:55 p.m., the DHS provided and identified a document as a current facility policy, titled, "Guidelines for Bathing Preference," dated 5/11/16. The policy indicated, "...POLICY...Guidelines for Bathing Preference...PURPOSE...To establish a personal preference bathing routine...PROCEDURES...2. The resident shall determine their preference for bathing upon admission...a. Day of the week...b. Time of day - morning or evening...c. Type of bathing - tub bath, bed bath, or shower...3. If the resident is unable to communicate their preference this information shall be obtained from the resident representative based on known history...4. Bathing shall occur at least twice a week unless resident preference states otherwise...." 3.1-3(u)(3)			
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral			

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	status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph			

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	(c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. Based on record review and interview, the facility failed to ensure report was called to the receiving hospital for a resident transfer for 1 of 4 residents reviewed for hospitalization (Resident 24). Findings include:	F 0622	1. Resident 24 suffered no ill effects from the alleged deficient practice. 2. Discharged residents have the potential to be affected by the alleged deficient practice and through alterations in processes and in servicing, nurses will be educated on requirements of	11/18/2022

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	Resident 24's closed record was reviewed on 10/24/22 at 10:52 a.m. The profile indicated the resident had been admitted to the facility on 5/9/22, for diagnoses which included, but were not limited to, peritonitis (inflammation of the peritoneum, typically caused by bacterial infection either via the blood or after rupture of an abdominal organ) and surgical aftercare following surgery on the digestive system. The census indicated the resident had 4 plus re-hospitalizations since his admission to the facility which included, but were not limited to, 5/8/22 to 6/1/22, 7/1/22 to 7/14/22, 8/12/22 to 8/17/22, 9/5/22 to 9/9/22, 9/26/22 to 9/29/22, and 10/4/22 to 10/17/22. A progress note, dated 10/4/22 at 3:40 a.m., indicated on 10/4/22 at 3:15 a.m., the resident was complaining he felt like he was having chest pain. Nitroglycerine (a substance used as a drug to treat certain heart conditions and to widen the openings in blood vessels) was administered and was effective. Vital signs were assessed and were within normal limits. Within twenty minutes of the resident being administered a series of nitroglycerine, he requested to go to the hospital. Vital signs were checked again and were within normal limits. The Assistant Director of Health Services (ADHS) was contacted, and ambulance was contacted to transport resident to the hospital. The required transfer and discharge and bed hold documents were observed complete and had been documented as provided to the resident at the time of the transfer. The record lacked documentation the facility called a report to the receiving hospital prior to		calling report with the receiving facility. 3. As a measure of ongoing compliance, director of health services (DHS) or designee will audit 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 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.	

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	the transfer. During an interview, on 10/24/22 at 11:21 a.m., the Director of Health Services (DHS) indicated she had been unable to find any documentation of report for the transfer having ever been called to the hospital. Normally the facility staff were very good at calling in report, but they were not very good at documenting the contact. On 10/24/22 at 11:47 a.m., the Minimum Data Set (MDS) Consultant provided a document, dated 5/3/17, titled, "Guidelines for Transfer and Discharge," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedures...2. Emergency Transfers/Discharges...b. Nursing should contact...provider hospital...for...admission arrangements...." 3.1-12(a)(3)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and			

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(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
	assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, record review, and interview, the facility failed to ensure interventions were provided for a contracture (fixed tightening of muscle, tendons, ligaments, or skin) and assistance to maintain hygiene to the contracted area for 1 of 1 residents reviewed for limitation in range of motion (ROM) (Resident 1). Findings include: On 10/17/22 at 11:33 a.m., Resident 1 was observed with contracted bilateral hands. The left hand had long, untrimmed fingernails, and was in a tightly closed fist. The thumb and first finger were visualized, and the rest of the fingers were tightly closed into the palm. No padding or splint devices were observed. On 10/19/22 at 11:29 a.m., Resident 1's left hand was observed to be contracted. The fingernails on the left hand were long and untrimmed. The thumb and first finger were visualized with dark debris underneath them. The rest of the fingers were tightly closed into the palm. No padding or splint devices were observed. Resident 1's record was reviewed on 10/19/22 at 11:52 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 7/28/22, indicated the resident had a severe cognitive impairment, had not rejected care, required extensive assistance of 2 staff members for personal hygiene, and had functional limitation in ROM on both sides of the upper extremities. Diagnoses on the resident's profile included, but	F 0688	1. Resident #1 was affected, brace applied with no adverse effects noted and nails were immediately cleaned. 2. Residents with contracture have potential to be affected. Those with contractures were audited to ensure nail care was given, has an updated care plan, and care plan interventions are in place. Nursing staff educated to ensure they are aware of the interventions and proper nail care. 3 As a measure of ongoing compliance, director of health services (DHS) or designee will audit 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months to ensure an updated care plan is in place, resident nails are clean, and proper interventions are in place. 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.	11/18/2022

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	155830	A. BUILDING 00 B. WING	10/25/2022

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	were not limited to, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) unspecified. Census information indicated the resident was placed on hospice (specialized care for the terminally ill) care on 7/23/20. A current care plan, initiated 12/8/21, indicated the resident was limited in ROM to the left arm and hand and right arm. Interventions included but were not limited to ensure protective padding is in place and splint per physician's orders. A current care plan, initiated 4/21/22, indicated the resident was at risk for decline in ROM related to upper extremities. The goal indicated the resident active ROM (exercises where movement is initiated by the resident, not an outside force) to upper extremities without signs or symptoms of pain. Interventions included but were not limited to encourage the resident to participate in the program and praise efforts. Progress notes, dated October 2022, lacked documentation the resident refused nail care or hand hygiene, participated in active ROM, or used a splint device. Current physician's orders lacked documentation of an order for active ROM or splint device. On 10/21/22 at 9:18 a.m., Resident 1 was observed at the nurse's station. The thumb and first fingernails on the resident's left hand were observed long, untrimmed, with dark debris underneath the first finger. The other fingers were tightly closed into the palm. No padding or splint devices were observed. At the same time, Licensed Practical Nurse (LPN) 3 assisted			

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	Resident 1 to open the left hand. There was brown greasy debris around the resident's left thumb and in the palm area. The rest of the fingers were unable to be clearly visualized as the hand was tightly closed. LPN 3 indicated the resident's hand needed cleaned, and the fingernails needed cleaned and trimmed. The resident sometimes refused to have her fingernails trimmed, but she was not sure if this was documented anywhere. The Certified Nursing Assistants (CNAs) did passive ROM (movement of joints due to outside force) with the resident, but the resident was not able to do any active ROM. The resident did not have any splints or devices for the contractures. During an interview, on 10/21/22 at 9:50 a.m., the MDS Consultant indicated the CNAs provided passive ROM during the resident's regular care, however this was not documented. The resident had a soft grip device for inside the hand, and it was worn as tolerated. If it was dirty, a washcloth should have been used. During an interview, on 10/21/22 at 10:37 a.m., the MDS Consultant indicated there was no facility policy for nail care, but it should have been done with showers and as needed. Refusals should have been documented. On 10/21/22 at 11:45 a.m., the MDS Consultant provided a document titled, "Comprehensive Care Plan Guideline," and indicated it was the policy currently being used by the facility. The policy indicated, "...POLICY: Comprehensive Care Plan Guideline. PURPOSE: To ensure appropriateness of services and communication that will meet the resident's needs, severity/stability of conditions, impairment, disability, or disease in accordance with state and federal guidelines. PROCEDURE: ...d. A comprehensive care plan will be developed			

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	within 7 days of completion of the admission comprehensive assessment...i. Problem areas should identify the relative concern. ii. Goals should be measurable and attainable. iii. Interventions should be reflective of the individual's needs and risk influence as well as the resident's strengths...4. Pertinent care plan approaches are communicated to the nursing staff...6. Comprehensive care plans need to remain accurate and current...." 3.1-42(a)(2)			
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 a nebulizer (a drug delivery device used to administer medication in the form of a mist inhaled into the lungs) mask was stored properly and humidification (a bottle of water attached to the oxygen tubing on an oxygen concentrator to provide humidity to the air flow through the tubing) was provided with oxygen use for 1 of 2 residents reviewed for respiratory care (Resident 52). Findings include:	F 0695	1. Resident 52 was not affected by alleged deficient practice. Resident 52 was provided with humidification and a plastic respiratory bag to store nebulizer mask when not in use. 2. Residents with O2 and nebulizers have the potential to be affected by the alleged deficiency and through alterations in processes and in-servicing the campus nursing staff will ensure that the residents have humidification hooked if	11/18/2022

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	During the initial pool observation, on 10/17/22 at 2:20 p.m., Resident 52's nebulizer mask was observed un-bagged and laying on his bed side table (BST). Several tissues with a reddish-brown substance were observed lying on the floor around his bed and in his bed. The resident was observed to have oxygen (O2) administered via nasal cannula (NC-a device used to deliver supplemental oxygen or increased airflow to a patient or person in need of respiratory help) from an oxygen concentrator (a device that concentrates the oxygen from a gas supply by selectively removing nitrogen to supply an oxygen-enriched product gas stream) sitting next to his bed. At the same time, the resident indicated the tissues had blood from his nose on them because his O2 did not have any humidity connected to it. It made his nose very dry and caused it to bleed. The nursing staff was aware and had told him they did not have the proper connectors to attached the humidity to his oxygen. Observation of the resident's O2 concentrator indicated the tubing was not connected to the humidification bottle on the concentrator. During a random observation, on 10/18/22 at 1:45 p.m., the resident's nebulizer was no longer sitting out on the BST. The O2 concentrator tubing was not connected to the humidification bottle. During a random observation, on 10/19/22 at 11:08 a.m., the resident's O2 tubing was not connected to the humidification bottle. Several tissues with a reddish-brown substance were observed on the resident's bed. At the same time, the resident indicated his nose remains dry and continued to bleed from time to time.		appropriate and nebulizer bags are placed in resident's rooms to place masks in when not in use. 3. Residents rooms with oxygen and nebulizers in use will be observed for humidification and a plastic respiratory bag to store nebulizer mask when not in use. Nursing staff will be educated on process of providing humidification when necessary and a plastic respiratory bag to store nebulizer mask when not in use. As a measure of ongoing compliance, director of health services (DHS) or designee will audit 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 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.	

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	Resident 52's record was reviewed on 10/19/22 at 2:35 p.m. The profile indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) with acute exacerbation (the phenomenon of sudden worsening in airway function and respiratory symptoms in patients with COPD), chronic systolic (congestive) heart failure (occurs when the left ventricle can't pump blood efficiently), and shortness of breath (SOB). An nursing admission assessment, dated 9/30/22, indicated the resident used supplemental oxygen. An admission Minimum Data Set (MDS) assessment, dated 10/3/22, indicated the resident had moderate cognitive deficit and required oxygen therapy. A care plan, dated 9/30/22, indicated the resident was at risk for complications related to respiratory disease. Interventions included, but were not limited to administer oxygen per physicians order and observe and report signs of respiratory distress. A physician's order, dated 10/3/22, indicated oxygen at 2 liters (L) per NC continuous. A physician's order, dated 10/6/22, indicated ipratropium-albuterol solution (medications that are breathed in through the mouth to open up the bronchial tubes [air passages] in the lungs) for nebulization, 0.5 milligrams (mg)-3 mg (2.5 mg base)/3 milliliters (mL). Amount to administer, 3 mL per inhalation. Four times daily (QID) as needed (PRN). Review of the October 2022 Medication Administration Record (MAR) indicated the			

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	resident's last documented treatment had been administered on 10/10/22. During an interview, on 10/19/22 at 3:06 p.m., the Director of Health Services (DHS) indicated she had picked up several dirty tissues from the resident's room the previous day. She was unable to explain why the humidification bottle had not been not connected to his O2 tubing. During an interview, on 10/20/22 at 11:20 a.m., the DHS indicated the last documentation of a nebulizer treatment was the one given by Registered Nurse (RN) 8 on 10/10/22. She was not sure why the nebulizer would have been left out. She believed there was a bag for it to be stored in the drawer of the resident's BST. During an interview, on 10/20/22 at 11:38 a.m., RN 8 indicated she was the resident's primary nurse. She believed she had became aware of the resident's nose being dry from his O2 and having slight nose bleeds, during her shift on 10/12/22. She had attempted to hook up the humidification bottle for him, but could not keep the tubing attached to the bottle, and was afraid that the tubing would continue to come off and he would end up with no O2 flow at all. She had explained the situation to the person who was in charge of handling the facility supplies, at that time. She had not been scheduled to work again until this current week. On 10/20/22 at 11:20 a.m., the DHS provided a document, dated 5/11/16, titled, "Respiratory Equipment," and indicated it was the policy currently being used by the facility. The policy indicated, "...SOP (Standard of Practice) Details...2. Oxygen Administration...b. Use sterile distilled water water for humidification...as			

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	needed...3. Medication Nebulizers...f. Store...in plastic bag, marked with date and resident's name, between uses...." 3.1-47(a)(6)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.			

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	§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to ensure nurse staffing information was posted daily for 2 of 7 observations of staff postings. Finding includes: On 10/17/22 at 9:35 a.m., observation of the staffing information posted at the facility's front desk was dated 10/14/22. On 10/21/22 at 9:01 a.m., observation of the staffing information posted at the facility's front desk was dated 10/20/22. On 10/21/22 at 10:06 a.m., the Executive Director (ED) observed the nurse staffing information posted at the facility's front desk, dated 10/20/22, and indicated the nurse staffing information should be updated daily. It just got missed. On 10/21/22 at 11:40 a.m., the ED indicated at the beginning of the day the staff posting will be updated and posted daily in the facility. The ED provided and identified a document as the current facility policy titled, "Guidelines for Staff Posting," dated 5/11/16. The policy indicated, "...POLICY...Guidelines for Staff Posting...PURPOSE...To ensure compliance with federal regulations requiring posting on a daily basis for each shift, the number of nursing personnel responsible for providing direct resident care...PROCEDURES...1. At the beginning	F 0732	1. No residents suffered ill effects from the alleged deficient practice. 2. ED or Designee will check daily by 9:30 for 4 weeks, then every other week for 2 months, and then monthly for 3 months to ensure the staffing information is posted daily. Instructions for printing the staffing information will be kept at the front desk.	11/18/2022

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	of the day the number and amount of hours of licensed nurses (RN and LPN) and the number and hours of unlicensed nursing personnel, per shift, who provide direct care to residents will be posted...." 3.1-13(i)(4)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure pain assessments were completed with administration of as needed (PRN) pain medication for 1 of 5 residents reviewed for unnecessary medications (Resident 7).	F 0757	1. Resident 7 suffered no ill effects from the alleged deficient practice. Resident's PRN pain medication order was clarified adding the pain severity, location and how many tabs to administer.	11/18/2022

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	Findings include: Resident 7's record was reviewed on 10/18/22 at 2:23 p.m. An admission Minimum Data Set (MDS) assessment, dated 8/1/22, indicated the resident had a severe cognitive impairment. Diagnoses on the resident's profile included, but were not limited to, displaced bimalleolar fracture (break near the end of both leg bones, near the ankle) of left lower leg, subsequent encounter for closed fracture (not broken through the skin) with routine healing. Census information indicated the resident was admitted to the facility on 7/29/22. A care plan, initiated 7/29/22, indicated the resident was at risk for pain related to ankle fracture. Interventions included, but were not limited to, administer medications as ordered. A physician's order, dated 7/30/22, indicated acetaminophen (a medication for pain and fever reduction) 325 milligrams (mg), administer 1 or 2 tablets by mouth every 6 hours PRN. A medication administration record (MAR), dated July 2022, indicated the resident received acetaminophen twice for pain, and both administrations lacked documentation of the pain severity, location, and if 1 or 2 tablets were administered. A MAR, dated August 2022, indicated the resident received acetaminophen 6 times for pain, but all administrations lacked documentation of the pain severity, location, and if 1 or 2 tablets were administered.		2. All residents with PRN pain medications have the potential to be affected. Current residents with PRN pain medication orders were audited to include pain severity, location of pain, and how many tabs to administer. 3. Active nursing staff have been educated on pain assessments and indicating number of tablets to be separated. Systemic change is campus will review PRN pain medications in CCM to assure PRN orders contain pain severity, location, and number of tabs in separate orders if indicated. As a measure of ongoing compliance, director of health services (DHS) or designee will audit 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 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.	

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	A MAR, dated September 2022, indicated the resident received acetaminophen 5 times for pain, but all administrations lacked documentation of the pain severity, location, and if 1 or 2 tablets were administered. A MAR, dated October 2022, indicated the resident received acetaminophen once for pain, but lacked documentation of the pain severity, location, and if 1 or 2 tablets were administered. During an interview, on 10/19/22 at 10:54 a.m., the Director of Health Services (DHS) indicated when a PRN pain medication was administered the pain scale, location, and actual amount of medication administered should have been documented. On 10/19/22 at 11:22 a.m., the DHS provided a document titled, "ADMINISTRATION OF PRN MEDICATIONS," and indicated it was the policy currently being used by the facility. The policy indicated, "...OVERVIEW: To provide SOP for the administration of non-routine (PRN) medication administration. SOP DETAILS: 1. Prior to administration of PRN medication, the nurse shall review the physician orders and note any parameters for administration...3. Documentation should reflect the reason for administering the PRN medication...." 3.1-48(a)(3)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when			

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	applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure an opened multi-dose vial of tuberculin (TB) protein derivative solution (a sterile solution containing the growth products of or specific substances extracted from the tubercle bacillus and used in the diagnosis of tuberculosis) had documentation of the date the vial was opened for use for 1 of 2 medication storage rooms reviewed. Findings include: During observation of the 100 hall medication storage room refrigerator, on 10/24/22 at 2:17 p.m., a vial of TB derivative solution was observed opened with no documented open date. At the same time, Licensed Practical Nurse (LPN) 9 indicated he had removed the vial from the 200	F 0761	1. No residents suffered ill effects from the alleged deficient practice. TB solution was updated with documentation of open date. 2. Campus residents and staff have the potential to be affected. Both medication rooms with TB solution were checked to ensure open dates were noted on the solution. 3. Nursing staff were educated on placing open dates on the TB solutions when first dose is given. As a measure of ongoing compliance, director of health services (DHS) or designee will audit both medication rooms weekly for 4 weeks, then every other week for 2 months, and then	11/18/2022

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	155830	A. BUILDING 00 B. WING	10/25/2022

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	hall medication storage refrigerator a couple of days ago. During an interview, on 10/24/22 at 2:25 p.m., the Assistant Director of Health Services (ADHS) indicated multi-dose vials of medications should always be dated when opened. On 10/24/22 at 2:44 p.m., the Minimum Data Set (MDS) Consultant provided a document, dated 11/2018, titled, "Medication Storage in the Facility," and indicated it was the policy currently being used by the facility. The policy indicated, "...D. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. 1) A "date opened"...shall be placed on the medication...." 3.1-25(j) 3.1-25(k)(6)		monthly for 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.	
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents			

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	from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure hand hygiene was completed when assisting residents to eat during 1 of 2 dining observations (Residents 54 and 18). Findings include: During a continuous dining observation, on 10/21/22 from 12:29 p.m. to 12:47 p.m., Certified Resident Care Assistant (CRCA) 4 was observed assisting Residents 54 and 18 to eat lunch. CRCA 4 adjusted her face mask with her bare hand, then picked up Resident 54's fork and gave him a bite of food. CRCA 4 stepped away from Resident 54's and Resident 18's table, grabbed a clothing protector, placed the clothing protector onto Resident 18, then gave Resident 54 a bite of food. CRCA 4 adjusted Resident 18's wheelchair back for the resident to sit upright, picked up a cup and held the cup's drinking straw between her fingers while she gave Resident 18 a drink. CRCA 4 sat down the cup onto the dining table and gave Resident 54 a bite of food, then scratched the top of her head and adjusted her face mask with her bare hand. CRCA 4 cut up Resident 18's food and gave Resident 18 a bite of food. CRCA 4 adjusted her face mask, gave Resident 54 a bite of food, then gave Resident 18 a bite of food. CRCA 4 picked up a spoon and dessert cup, gave Resident 54 a bite of dessert, then handed the spoon and dessert cup to CRCA 5. CRCA 5 gave Resident 54 bites of the dessert. No hand hygiene was	F 0812	1. Residents 54 and 18 suffered no ill effects of alleged deficient practice. Staff feeding in the dining room were educated on proper hand hygiene during restorative dining activity. 2. All restorative dining residents have the potential to be affected. Restorative dining processes have been observed to ensure proper hand hygiene is in place during feeding activity. 3. Active nursing staff have been educated on proper hand hygiene. As a measure of ongoing compliance, executive director (ED) or designee will observe 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 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.	11/18/2022

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	observed performed during the continuous dining observation. On 10/21/22 at 1:12 p.m., the Minimum Data Set (MDS) Consultant indicated, staff should sanitize their hands before assisting a resident with eating. At that time, the MDS Consultant provided and identified a document as a current facility policy titled, "Guideline for Handwashing/Hand Hygiene," dated 2/9/17. The policy indicated, " ...POLICY ...Guideline for Handwashing/Hand Hygiene ...PURPOSE ...Handwashing is the single most important factor in preventing transmission of infections. Hand hygiene is a general term that applies to either handwashing or the use of an antiseptic hand run, also known as alcohol-based hand rub (ABHR) ...3. Health Care Workers shall use hand hygiene at times such as ...b. Before/after preparing/serving meals, drinks ...." 3.1-21(i)(3)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: October 17, 18, 19, 20, 21, 24, and 25, 2022. Facility number: 013335 Residential Census: 40 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on November 3, 2022.	R 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 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	

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			maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of 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.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations			

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	subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure service plans were signed by the resident or resident representative for 2 of 7 service plans reviewed (Residents 546 and 502). Findings include: 1. Resident 546's closed record was reviewed on 10/25/22 at 10:35 a.m. The profile indicated the resident had been admitted to the facility on 1/15/22. Service plans, dated 1/15/22 and 7/19/22, lacked documentation of a signature from the resident or the resident's representative. During an interview, on 10/25/22 at 2:04 p.m., the Executive Director (ED) indicated they were unable to find any documentation of the service plan being signed by the resident or resident representative. 2. Resident 502's record was reviewed on 10/25/22 at 10:55 a.m. The profile indicated the resident had been admitted to the facility on 12/1/21. The resident's admission service plan, dated 12/1/21, lacked documentation of a signature from the resident or the resident's representative. During an interview, on 10/25/22 at 11:20 a.m., the Director of Health Services (DHS) indicated she	R 0217	1. Residents # 546 and 502 have their service plans signed and dated. 2. All residents have the potential to be affected by the alleged deficient practice and through alterations in processes and in servicing the campus will ensure service plans are signed and dated by the resident and/or responsible party. 3. An in-service has been completed with licensed nurses concerning completing the assisted living service plan and the importance of having the resident and/or responsible party sign and date the service plan. The systemic change is service plans will be reviewed monthly by the assisted living unit manager/designee to assure the resident and/or responsible party have signed and dated the service plan. 4. DHS/Designee will AL director, LLD, or designee to audit all new admissions and significant changes X6 months with results forwarded to the QA committee monthly x 6 months and quarterly thereafter for review and further	11/18/2022

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	was not able to locate a service plan which had been signed by the resident and/or the resident's representative. On 10/25/22 at 11:55 a.m., the DHS provided a document, dated 12/11/17, titled, "AL-Evaluation and Service Plan Guidelines," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedures...2. A service plan shall be identified and implemented...in collaboration with the resident and/or responsible party...."		suggestions/comments.	