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	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR CORYDON, IN 47112

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00391893 and IN00391941. Complaint IN00391893 - Unsubstantiated due to lack of sufficient evidence. Complaint IN00391941 - Substantiated. No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey dates: October 21 and 24, 2022 Facility number: 010597 Provider number: 155657 AIM number: 200204440 Census Bed Type: SNF/NF: 89 Total: 89 Census Payor Type: Medicare: 28 Medicaid: 49 Other: 12 Total: 89 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 31, 2022.	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 complaint survey conducted on October 21 and 24, 2022. 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**	
F 0557 SS=D Bldg. 00	483.10(e)(2) Respect, Dignity/Right to have Prsnl Property §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brandon Jensen	LNHA	11/14/2022

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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	§483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. Based on interview and record review, the facility failed to ensure permission was granted for a room search for 1 of 3 residents reviewed for resident rights. (Resident D) Findings include: The clinical record for Resident D was reviewed on 10/21/22 at 11:59 a.m. The diagnoses included, but were not limited to, traumatic subarachnoid hemorrhage, depression and diabetes. The progress note, dated 10/1/22 at 11:30 a.m., indicated the resident was found outside in the courtyard smoking. The resident gave the cigarette and lighter to staff. The progress note, dated 10/4/22 at 12:45 p.m., indicated a room search was completed and no smoking material was found. The clinical record lacked documentation of the resident or the resident's representative permission for a room search. During an interview on 10/24/22 at 11:51 a.m., the Director of Nursing indicated she did notify the family but did not document the notification. On 10/24/22 at 2:25 p.m., the Director of Nursing provided a current undated copy of the document titled "Resident Rights". It included, but was not limited to, "Dignity...a state worthy of honor and respect...Policy...It is the policy of this facility to	F 0557	**STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** Resident D was not harmed by the deficient practice **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All resident in facility could be affected by deficient practice. A 30 day look back of resident room searches completed to ensure permission was granted by resident/representative. Any identified concerns were immediately addressed **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/DON/Designee held an in-service for administrative, nursing and direct care staff to provide education and expectations as it relates to “Residents Rights” policy to include appropriate room search procedures including resident grants permission and permission s documented. **STEP 4 Corrective actions to be monitored to ensure the**	11/04/2022

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	provide resident centered care...Procedure...Residents will be treated with dignity and respect...." 3.1-3(a)		**deficient practice will not recur:** The Director of Nurses/ Designee will audit 5 residents per 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 proper room search procedures are followed including resident granting permission and permission is documented. 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.	
F 0624 SS=D Bldg. 00	483.15(c)(7) Preparation for Safe/Orderly Transfer/Dschrg §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. Based on interview and record review, the facility failed to ensure a resident (Resident D) was educated on medication administration upon discharge; failed to ensure a physician order for discharge home was in place; and failed to ensure	F 0624	**STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** Resident D was not harmed by the	11/04/2022

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	a bed hold was provided at the time of discharge for 1 of 3 residents reviewed for Admission/Transfer/Discharge. Findings include: The clinical record for Resident D was reviewed on 10/21/22 at 11:59 a.m. Diagnoses included, but were not limited to, hypertension, chronic obstructive pulmonary disease, depression, hyperlipidemia and diabetes. The progress note, dated 10/17/22 at 8:46 a.m., indicated the resident discharged home via facility bus and all personal belongings were packed and sent with the resident. The clinical record lacked documentation of a physician's order to discharge home, education provided to the resident for medication administration, and a bed hold policy On 10/24/22 at 11:51 a.m., the Director of Nursing indicated prior to discharge, there should be a discharge order in place and ensure the resident understands the medication and how to take them. On 10/24/22 at 2:12 p.m., the Director of Nursing indicated she could not find a discharge order, bed hold policy, or education provided to the resident upon discharge. On 10/24/22 at 11:36 a.m., the Executive Director provided a current copy of the document titled "Admission, Discharge and Transfer" dated 9/20/22. It included, but was not limited to, "Policy...It is the policy of this facility to provide resident centered care that meets the...needs...of the residents. Safety is a primary concerns for our residents...Procedure...Discharge		deficient practice **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Residents discharging home have the potential to be affected by the deficient practice. A 30 day look back of resident discharges has been completed to ensure the discharged resident received medication administration education, a copy of the provision of behold policy, and a physician order is in place for the discharge. Any identified concerns were immediately addressed. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/DON/Designee held an in-service for licensed nursing and social service staff to provide education and expectations as it relates to "Admission, Discharge, and Transfer" policy to include medication administration education, physician order for discharge home, and providing a copy of the provision of behold policy. **STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:** The Director of Nurses/ Designee will audit 3 discharges per week x	

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	Notice...Contents of the notice...The facility's notice must include all of the following...specific reason for the...discharge...The specific location...to which the resident is to be...discharged...All special instructions...All other information necessary to meet the resident's needs, which includes...Medications...For residents being discharged (return not expected), the facility must convey all of the information listed above...." 3.1-12(a)(16(21)		4 weeks, then 2 discharges per week x 4 weeks, then 1 discharges week x 4 weeks for no less than 3 months and compliance is maintained to ensure discharged residents received medication administration education a copy of the provision of bed hold policy and a physician order is in place for the discharge 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.	
F 0712 SS=D Bldg. 00	483.30(c)(1)-(4) Physician Visits-Frequency/Timeliness/Alt NPP §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician,			

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	required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. Based on interview and record review, the facility failed to ensure a resident (Resident D) received the required visits from the physician for 1 of 3 residents reviewed for physician visits. Findings include: The clinical record for Resident D was reviewed on 10/21/22 at 11:59 a.m. Diagnoses included, but were not limited to, hypertension, chronic obstructive pulmonary disease, depression, hyperlipidemia and diabetes. Review of the clinical record indicated the resident was seen by the physician on 4/27/22 at 3:20 p.m. and last seen by the nurse practitioner on 6/6/22 at 5:44 p.m. The clinical record lacked documentation of any other physician visits prior to the resident's discharge on 10/17/22. During an interview on 10/24/22 at 2:57 p.m., the Executive Director indicated residents should have physician visits every 60 days. On 10/24/22 at 2:55 p.m., the Director of Nursing provided a current undated copy of the document titled "General Physician Services". It included, but was not limited to, "Policy...It is the policy of this facility to provide resident centered care...Attending physician/provider...Will assume the care of the resident during the resident's entire	F 0712	**STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** Resident D was not harmed by the deficient practice **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All facility residents could be affected by deficient practice. A 100% audit of all resident physician visits has been completed to ensure timely primary care physician visits have occurred. A physician was immediately scheduled for any resident that was found to be out of compliance. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/DON/Designee held an in-service for licensed nursing staff and current facility primary care providers to provide education and expectations as it relates to “General Physician Services” policy to include minimum required physician visits. **STEP 4 Corrective actions to be**	11/04/2022

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	stay...Evaluation Requirements...Residents will be evaluated by a physician at least once every thirty days for the first ninety days...After this period, each resident will be evaluated every sixty days. A physician extender may share the every sixty day visits, but the physician must see the resident no less that every 120 days...."		**monitored to ensure the deficient practice will not recur:** The Director of Nurses/Electronic Health Record (EHR) Nurse/ Designee will audit 10 resident per week x 4 weeks, then 5 residents per week x 4 weeks, then 2 residents per week x 4 weeks for no less than 3 months and compliance is maintained to ensure physician visits were providing in accordance with facility policy including documentation of minimum required physician visits. 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.	