STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING _____ B. WING _____	R-C 12/12/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the unrelated deficiencies from the Investigation of Complaints IN00391893 and IN00391941 completed on October 24, 2022. This visit was in conjunction with the PSR to the Recertification and State Licensure Survey and to the Investigation of Complaints IN00389906, IN00391278, and IN00388039 completed on October 3, 2022. This visit was in conjunction with the PSR to the Investigation of Complaint IN00393912 and the COVID-19 Focused Infection Control Survey completed on November 7, 2022. Unrelated deficiencies - Corrected Complaint IN00389906 - Corrected Complaint IN00391278 - Corrected Complaint IN00388039 - Corrected Complaint IN00393912 - Corrected Survey date: December 12, 2022. Facility number: 010597 Provider number: 155657 AIM number: 200204440 Census Bed Type: SNF/NF: 70 Total: 70 Census Payor Type:	{F 000}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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
	155657	A. BUILDING _____ B. WING _____	R-C 12/12/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000}	Continued From page 1 Medicare: 8 Medicaid: 55 Other: 7 Total: 70 Harrison Healthcare Center was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the unrelated deficiencies from the Investigation of Complaints IN00391893 and IN00391941. Quality review completed on December 16, 2022.	{F 000}		