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	12/18/2024

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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00448070 and IN00448620. Complaint IN00448070 - No deficiencies related to the allegations are cited. Complaint IN00448620 - No deficiencies related to the allegations are cited. Survey dates: December 12, 13, 16, 17 and 18, 2024 Facility number: 010597 Provider number: 155657 AIM number: 200204440 Census Bed Type: SNF/NF: 83 Total: 83 Census Payor Type: Medicare: 6 Medicaid: 60 Other: 17 Total: 83 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 29, 2024.	F 0000	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The plan of correction is submitted in order to respond to the allegation of non compliance sited during the annual survey conducted on December 12, 13, 16, 17, and 18, 2024. Please accept this plan of correction as the providers credible allegation of compliance. The facility would respectfully request a desk review. Sandra Pace HFA	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on observation, record review and interview, the facility failed to respect the dignity	F 0550	1) Residents 283 and 34 were not harmed by the alleged	01/20/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sandra Pace	HFA	01/13/2025

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	of residents related to ensuring the urine side of the indwelling catheter bag was not in sight of those who passed by a resident's room and to ensure a staff member spoke to a resident in a dignified manner for 2 of 20 residents reviewed for Resident Rights. (Residents 283 and 34) Findings include: 1. During an observation on 12/12/24 at 10:00 a.m., Resident 283's indwelling catheter bag was not in a dignity bag and hanging off the right side of the resident's bed. The bag showed clear urine in the bag visible from the hallway. During an observation on 12/12/24 at 12:43 p.m., the resident's indwelling catheter bag was not in a dignity bag and hanging off the right side of the resident's bed. The bag showed clear urine in the bag visible from the hallway.the catheter bag was hanging off the right side of the bed which showed the clear urine side of the bag. There was urine in the bag. During an observation on 12/12/24 2:15 p.m., the resident's indwelling catheter bag was not in a dignity bag and hanging off the right side of the resident's bed. The bag showed clear urine in the bag visible from the hallway.the catheter bag was hanging off the right side of the bed which showed the clear urine side of the bag. There was urine in the bag. During an observation on 12/13/24 10:15 a.m., the resident's indwelling catheter bag was not in a dignity bag and hanging off the right side of the resident's bed. The bag showed clear urine in the bag visible from the hallway.the catheter bag was hanging off the right side of the bed which showed the clear urine side of the bag. There was		deficient practice. Resident 283 dignity bag was put in place, plan of care was reviewed. Resident 34 was assessed and no psychosocial distress noted, plan of care reviewed. 2) (A) All residents with a catheter are at risk. 100% visual audit completed for residents with a catheter to ensure dignity bags in place. (B) All residents that LPN 12 cared for the last 14 days have the risk to be affected, interviews to be completed on residents with a BIMs of 10 and greater, psychosocial assessments for Residents with BIMs of 9 or less. All concerns will be addressed immediately with MD, family notifications and care plans reviewed. 3) DON/Designee will educate all staff on company's resident rights policy and procedure, emphasizing on dignity bags for catheters and having appropriate conversations. 4) DON/Designee will audit 5 residents a week x 4 weeks, 3 residents a week x 4 weeks, then 1 resident a week x 4 weeks to validate dignity bags are in place. DON/Designee will interview/assess 5 residents a week x 4 weeks, 3 residents a week x 4 weeks, then 1 resident a week x 4 weeks to assure staff are not having inappropriate conversations. DON/Designee will report on audits monthly to the	

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	urine in the bag. During an observation on 12/16/24 10:15 a.m., the resident's indwelling catheter bag was not in a dignity bag and hanging off the right side of the resident's bed. The bag showed clear urine in the bag visible from the hallway.the catheter bag was hanging off the right side of the bed which showed the clear urine side of the bag. There was urine in the bag. On 12/17/24 at 10:25 a.m., the resident's indwelling catheter bag was visible on the left side of the resident's bed. The indwelling catheter bag was without a dignity cover. The resident's urine was visible in the bag. The record for Resident 283 was reviewed on 12/13/24 at 10:00 a.m. The resident's diagnoses included, but were not limited to, immobility syndrome (paraplegic), malignant neoplasm of the prostate, and obstructive uropathy. During an interview on 12/17/24 at 11:10 a.m., CNA (Certified Nursing Aide) 2 indicated the resident was confused, required extensive assist of two staff members for transfers and bed mobility. He had an indwelling catheter and was incontinent of bowel. A physician's order, dated 12/11/24, indicated staff were to ensure the indwelling urinary catheter was in a privacy bag and catheter leg strap was on at all times A care plan, dated 12/13/24, indicated the resident had an indwelling catheter due to urinary retention and a malignant neoplasm of the prostate. The interventions included, but were not limited to, ensure securement device in place and		interdisciplinary team for 3 months during the QAPI Meeting. The IDT will determine if the audits are necessary to continue after 3 months with 100% compliance.	

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	provide catheter care every shift and PRN (as needed). During an interview on 12/17/24 at 11:17 a.m., CNA 2 indicated all residents whom had an indwelling catheter were supposed to have them in a privacy bag or be covered at all times to protect the resident's privacy. If a resident did not have a privacy bag staff were supposed to let the nurse know so she could get them one. During an interview on 12/17/24 at 11:20 a.m., LPN (Licensed Practical Nurse) 3 indicated residents with indwelling catheters were supposed to have them in some sort of protective covering so people couldn't see the urine. If the resident did not have a privacy bag, then nursing staff should have been notified to get them one. During an interview with the Director of Nursing (DON) on 12/17/24 at 1:17 p.m., she indicated any resident with an indwelling catheter should have a dignity cover on it. If the resident did not have a dignity cover then staff were to get them one. 2. The record for Resident 34 was reviewed on 12/16/24 at 10:44 a.m.. The residents' diagnoses included, but were not limited to, bipolar disorder, severe with psychotic features; dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance; major depressive disorder, recurrent, severe with psychotic symptoms; personal history of suicidal behavior; immobility syndrome, and falls. The care plan, dated 11/26/24, indicated the resident was prescribed mood stabilizing medication related to behavior management. The interventions, dated 11/26/24, included, but were not limited to, provide mood-stabilizing medication per the medical provider's orders,			

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	provide a calm environment and limit over stimulation, encourage the resident to voice feelings, discuss coping skills, and maintain consistent daily routine when possible. A Progress Note, dated 12/4/2024 at 16:48 p.m., indicated that a staff member was overheard cursing in Resident 34's room. There was no distress noted to the resident and the physician, ED (Executive Director), DON (Director of Nursing), and family were made aware of the incident. During an interview on 12/16/24 at 10:08 a.m., the DON indicated an incident had occurred on 12/04/24 involving Resident 34. LPN 12 had gone to complete an assessment on Resident 34 due to CNA 13 reporting a change in condition. The LPN found the resident was asleep and attempted to complete a set of vital signs. Resident 34 was startled with a male nurse in the room. Resident 34 started to be combative with the LPN and the LPN had told her to "shut up". The LPN was suspended, pending investigation. He would return that day (12/16/24) to complete education on Abuse and Burnout education. During a phone interview on 12/17/24 at 10:25 a.m., LPN 12 indicated he had been in Resident 34's room to assess a change in condition that had been reported to him. He reported that he did yell back at Resident 34 to "Shut the f*** up." He then stated that he had been asked to leave the building. He reported that he had not returned to work and that he completed in-services on customer service, Alzheimer's Dementia and Burn out. During an interview with the Activity Director on 12/17/24 at 10:44 a.m., she indicated hearing LPN			

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	12 curse at Resident 34 while in her room providing care. The Progress Notes for Resident 34 was reviewed on 12/16/24 at 10:44 a.m. The progress notes were dated 10/28/24 through 12/10/24 and indicated the resident had continued to have behaviors, but has had no increase in behaviors, or any new behaviors related to the incident on 12/04/24. On 12/17/24 at 1:20 p.m., the Regional Director of Clinical Operations provided the most current facility policy titled "Resident Rights". Review of this policy included, but was not limited to, indicated "Scope: The policy is applicable to all adult living centers. Definitions: DIGNITY: a state of worthy of honor or respect: includes but not limited to speaking respectively to the resident, providing privacy for care and treatment,...respecting resident choice and attending to needs in a timely fashion. Policy: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents...The purpose of this policy is to guide employees in the general principles of dignity and respect of caring for residents...Care for residents will be provided in safe and respectful manner that includes care in a private setting, as appropriate...Procedure: 1. Residents will be treated with dignity and respect including but not limited to:...b. iii. Staff will speak respectfully to residents...d. To have their privacy respected..." 3.1-3(a) 3.1-3(t)			
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids			

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	Based on record review and interview, the facility failed to ensure an appointment was scheduled for the placement of a port for 1 of 1 resident's reviewed for intravenous therapy. (Resident 63) Findings include: The record for Resident 63 was reviewed on 12/17/24 at 9:12 a.m. The resident's diagnoses included, but were not limited to, immobility syndrome (paraplegic), chronic inflammatory demyelinating polyneuritis, and bed confinement. The Admission MDS (Minimum Data Set) assessment, dated 9/27/24, indicated the resident was cognitively intact. The physician's order, dated 10/30/24, indicated a referral to the surgeon for port (venous) placement for intravenous (IV) access. The resident received IgG (Immunoglobulin) infusions long term care related to poor venous access. The care plan, dated 10/30/24, indicated Resident 63 was currently on intravenous therapy for infusion therapy related to chronic inflammatory demyelination. The interventions included, but were not limited to, administer IV medications and flushes per medical provider's orders. Observe for side effects and effectiveness. Report abnormal findings to medical provider, resident and the resident representative. Change the midline dressing 24 hours post insertion and then weekly. Observe for intact sutures. Change the tubing every 72 hours, or as needed. Flush with 10cc (cubic centimeters) of normal saline, followed by 3cc of heparin. Evaluate for signs and symptoms of infection. Obtain and monitor laboratory and diagnostic studies, as ordered. Report abnormal findings to medical provider, resident or resident	F 0694	1) Resident 63 was not harmed by alleged deficiency. Appointment made for consult for port placement. Care plan reviewed and updated. 2) All residents that receive any IV therapy are at risk. All residents with IV therapy will be reviewed to assure any follow up recommendations from MDs are addressed timely. Concerns will be addressed immediately with MD/family notifications, plan of care reviewed and updated. 3) DON/Designee will educate the licensed nursing staff on policy. 4) DON/Designee will audit 5 residents with IVs a week x 4 weeks, 3 residents a week x 4 weeks, then 1 resident weekly x 4 weeks to validate MD recommendations have been addressed. DON/Designee will report on audits monthly to the interdisciplinary team for 3 months during the QAPI Meeting. The IDT will determine if the audits are necessary to continue after 3 months with 100% compliance	01/20/2025

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	representative. Visually inspect the midline site each shift and note any bleeding redness, swelling, pain or drainage. The nurse's note, dated 10/28/24 at 5:59 p.m., indicated the resident had a midline placed to the right arm due to the IVIG transfusions. Vascular access indicated the resident needed a port placed if she was going to receive further infusions. The NP was made aware. The Nurse Practitioner (NP) note, dated 10/30/24, indicated the resident reported that her family physician had referred her for a port placement back in August, but it may have been ignored. The NP indicated she called the physician's office and spoke to staff, who indicated that a referral was sent to the physician's office in August. She was kind enough to re-fax that today at her request. The facility scheduler was informed of this and asked to follow up with the surgeon's office later that day or tomorrow. She was to ensure they received it and if an appointment was scheduled. The resident would keep the midline in place for now. The staff at the physician's office indicated the resident would be on those infusions for a long time. The nurse's note, dated 10/30/24 at 11:08 a.m., indicated a referral for the resident's port placement was ordered at that time. The scheduler was made aware to proceed with faxing the referral packet. The NP note, dated 11/25/24 at 1:00 a.m., indicated the office was called on 11/23/24 related to red, tender, warm to touch, and slightly puffy around the midline (IV) site. The order was given to remove the midline. During her visit on 11/25/24, the resident's right upper arm was not swollen or			

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	warm to touch, but was tender. Her next infusion was the following week and would have to get another midline placed. The scheduler was supposed to call the surgeon's office where the resident was referred for port placement and to get an update on her referral status. The nurse's note, dated 11/29/24 at 1:06 p.m., indicated the resident had a midline placed to the left upper arm by the IV access team. The NP note, dated 12/2/24 at 1:00 a.m., indicated per the facility scheduler, the patient's previous physician was sending a referral for port placement as requested by surgeon's office. The NP was hoping this could be moved along quickly so a port could be placed and no further midlines. During an interview on 12/13/24 at 10:00 a.m., the resident indicated she was supposed to have a port put in but that hasn't happened yet. She thought that was two months ago and she did not understand why she had not seen the doctor for her port placement. She had a blood clot in her right arm. She had a Peripherally Inserted Central Catheter (PICC) line in her left upper arm and she was concerned she would get another blood clot. During an interview on 12/16/24 at 1:20 p.m., Patient Scheduler 7 indicated the resident's insurance company had her primary physician listed as her doctor and the facility had to get a referral from him. She indicated she was working on it. During an interview on 12/16/24 at 1:40 p.m., Business Office Manager (BOM) indicated the resident scheduler would schedule the appointment. The resident already have their Medicaid or Medicare numbers, and a face sheet			

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	would be sent with the resident to the appointment. The face sheet had all the information the doctor would need to bill the insurance company. The doctor's name would not need to be on the insurance because all they needed would be the insurance numbers. If the doctor or hospital had any questions, they would call the facility. During an interview on 12/16/24 at 2:11 p.m., the DON indicated she thought the delay had to do with the resident's insurance. Something about the primary physician. She would need to investigate it. During the survey, the DON did not present documentation indicating why the placement of the port was not scheduled as ordered by the physician. During an interview on 12/17/24 at 1:30 p.m., the Regional Director of Clinical Operations (RDCO) indicated it should not have taken months to get an appointment scheduled for the resident's port placement. 3.1-47(a)(2)			
F 0695 SS=E Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, record review, and interview, the facility failed to ensure oxygen concentrator filters were placed and maintained for 5 of 11 residents reviewed for respiratory care. (Residents 9, 14, 32, 45, 61) Findings include: 1. During an observation on 12/12/24 at 9:57 a.m., Resident 9's oxygen concentrator filter was 100% heavily covered with a white powdery substance.	F 0695	1) Residents 9, 14, 32, 45 and 61 were not harmed by the alleged deficient practice. Residents 9, 14, 32, 45 and 61 oxygen filters were cleaned immediately, plan of care was reviewed and updated. 2) All residents with oxygen have the risk to be affected, all residents with oxygen concentrators filters were cleaned.	01/20/2025

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	The oxygen tank's concentrator filter was pushed against the outer wall of the room. During an observation on 12/13/24 at 12:34 p.m. with the Director of Nursing (DON), the resident's oxygen concentrator filter was 100% (percent) heavily covered with a white powdery substance. The oxygen tank's concentrator filter was pushed against the outer wall of the room. The record for Resident 9 was reviewed on 12/17/24 at 8:14 a.m. The resident's diagnoses included, but were not limited to, emphysema, chronic obstructive pulmonary disease (COPD), malignant cancer of the bronchus or lung, and anxiety disorder. The physician's order, dated 1/19/22, indicated staff were to administer oxygen at 2.5 liters via nasal cannula, continuously and as needed every shift for shortness of breath. The Annual Minimum Data Set (MDS) assessment, dated 2/28/24, indicated the resident was moderately cognitively impaired. The resident required oxygen therapy. The care plan, revised 10/23/24, indicated the resident had oxygen therapy related to ineffective gas exchange, hypoxia, and COPD. The interventions, dated 12/13/21, indicated to administer 2.5 liters by nasal cannula for hypoxia and COPD diagnoses: Monitor for signs and symptoms of respiratory distress; and report to the MD (physician) PRN (as needed). The Nurse Practitioner (NP) note, dated 7/17/24 at 1:00 a.m., indicated therapy had informed her that the resident's O2 saturation was in the 70's on 4 liters of oxygen, per nasal cannula. She was		Education provided to patient/resident scheduler 7 on care and maintenance of oxygen concentrators. 3) DON/Designee will educate all staff on the oxygen therapy using concentrators policy and procedure. 4) DON/Designee will audit 5 residents a week x 4 weeks, 3 residents a week x 4 weeks, then 1 resident a week x 4 weeks to validate oxygen filters are clean. DON/Designee will report on audits monthly to the interdisciplinary team for 3 months during the QAPI Meeting. The IDT will determine if the audits are necessary to continue after 3 months with 100% compliance.	

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	usually on 2 liters. The resident was sitting in her wheelchair at the table in the gym doing some hand and arm exercises. She admitted to feeling short of breath and more tired. Her O2 (oxygen) saturation on the oximeter was 79%. Therapy increased the oxygen to 5 liters. A new machine was used to check the O2 saturation, and it indicated 96%. The resident's respiratory rate and pulse rate were slightly elevated. The physician's order, dated 10/23/24, indicated staff were to clean the oxygen concentrator filter with soap and water weekly and PRN (as needed) every day shift every Tuesday and Sunday and as needed for O2 care. The December 2024 Treatment Administration Record (TAR) indicated the oxygen concentrator filter was last cleaned on 12/10/24 by Licensed Practical Nurse (LPN) 6. During an interview on 12/13/24 at 1:50 p.m., the DON indicated the Patient Resident Scheduler 7 was responsible for cleaning the oxygen concentrator filters in the building. She also was responsible for documenting the cleaning of the filters in the TAR (Treatment Administration Record). During an interview on 12/13/24 at 2:00 p.m., Patient Resident Scheduler 7 indicated she normally cleaned the filters on Wednesdays. She was behind and didn't get to the filters until 12/12/24. She thought she had cleaned Resident 9's oxygen concentrator filter. Upon seeing the filter, she pulled it out of the concentrator and cleaned it in the resident's bathroom without hand hygiene or gloves. She indicated she must have just missed cleaning it. She felt that the heavy buildup of the white powdery substance was			

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	because the filters just became that way, quickly sometimes. It could have also been due to the filters being wet when she placed it back into the oxygen concentrators. The oxygen concentrator filters should be cleaned regularly, because the substance went into the resident's oxygen supply, and she didn't want it to do that. 2. During an observation on 12/12/24 at 9:19 a.m., Resident 14's oxygen concentrator filter was moderately covered at the corners with a white powdery substance. The record for Resident 14 was reviewed on 12/16/24 at 2:04 p.m. The resident's diagnoses included, but were not limited to, solitary pulmonary nodule, pulmonary embolism, heart failure, atherosclerotic heart disease, cardiac arrhythmia, anxiety disorder, and hospice care. The Annual MDS assessment, dated 4/27/24, indicated the resident was cognitively intact. The care plan, last reviewed 10/4/24, indicated the resident had congestive heart failure (CHF) with or without difficulty breathing. The interventions, dated 10/21/21, indicated to elevate the head of the bed as needed, for ease of breathing and monitor vitals; report abnormal findings to medical provider, resident or resident representative; observe for signs or symptoms of CHF; report any abnormal findings to medical provider, resident or resident representative; report resident complaints of chest pain to the medical provider, resident or resident representative; and dated 10/23/24 provide hospice services. The physician's order, dated 10/15/24, indicated to wean the resident off of O2. Check the O2 saturation every six hours. If the O2 saturation			

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	155657	A. BUILDING 00 B. WING	12/18/2024

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	was greater than 90%, remove the oxygen and if the resident maintained at greater than 90% after five minutes, leave off. If the O2 saturations dropped to less than 90%, keep the oxygen on. Check the oxygen every six hours. The physician's orders and December TAR lacked documentation for staff to clean the oxygen concentrator filters. The nurse's note, dated 11/25/24 at 2:52 p.m., indicated a Certified Nurse Aide (CNA) reported that Resident 14 "passed out" when transferring to her wheelchair. Upon assessment, the resident was minimally responsive to verbal stimuli but was able to track the nurse with her eyes. After approximately 30 seconds, the resident became more alert, and close to baseline. Her vital signs were obtained and were within normal limits. The hospice nurse was in the room and assisted the resident to bed with the assistance of two staff members. Once abed, the resident complained of chest pain to the hospice nurse. The PRN nitroglycerin was administered once and was effective with no further complaints voiced. 3. During an observation on 12/12/24 at 9:38 a.m., Resident 32's oxygen concentrator filter was moderately coated at the corners with a white powdery substance. The record for Resident 32 was reviewed on 12/17/24 at 10:14 a.m. The resident's diagnoses included, but were not limited to, COPD, heart failure, insomnia, and morbid obesity due to excess calories. The physician's order, dated 6/15/23, indicated to administer oxygen at 3 liters per minute via nasal cannula, continuously every shift for shortness of			

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	breath and as needed for shortness of breath. The physician's order, dated 6/18/23, indicated to clean the oxygen concentrator filter with soap and water weekly and PRN in the morning every Sunday for O2 care. The Quarterly MDS assessment, dated 6/18/24, indicated the resident was cognitively intact. The resident required oxygen therapy. The care plan, last reviewed 10/1/24, indicated the resident had oxygen therapy related to COPD and hypoxia. The interventions, dated 10/6/20 and revised 1/5/21, indicated to monitor for signs and symptoms of respiratory distress and report to the MD, PRN; dated10/6/20 and revised 8/29/22, the resident had O2 via nasal prongs at 3 liters continuously, humidified; dated 10/6/20 provide reassurance and allay anxiety; have an agreed-on method for the resident to call for assistance (e.g., call light, bell); and stay with the resident during episodes of respiratory distress. The December TAR indicated the oxygen concentrator filter was cleaned on 12/8/24 by LPN 6. 4. During an observation on 12/12/24 at 9:45 a.m., Resident 45's bilateral oxygen concentrator filters were both 100% heavily coated with a white powdery substance. The record for Resident 45 was reviewed on 12/16/24 at 9:20 a.m. The resident's diagnoses included, but were not limited to, old myocardial infarction, COPD, morbid obesity due to excess calories, atherosclerotic heart disease with unstable angina pectoris, anxiety disorder, adult failure to thrive, altered mental status, vascular			

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	dementia, anxiety, and seizures. The physician's order, dated 3/15/23, indicated to clean the oxygen concentrator filter with soap and water weekly and PRN every day shift every Wednesday for O2 care. The Annual MDS assessment, dated 2/28/24, indicated the resident was moderately cognitively impaired. The resident required oxygen therapy. The nurse's note, dated 6/9/24 at 12:25 a.m., indicated the resident experienced occasions of shortness of air with exertion. The care plan, dated 11/26/24, indicated the resident had oxygen therapy related to ineffective gas exchange and hypoxia. The interventions, dated 3/9/23, indicated to administer 2 liters by nasal cannula for hypoxia and COPD; dated 10/23/24 encourage or assist the resident with ambulation as indicated; and dated 3/9/23 monitor for signs or symptoms of respiratory distress and report to the MD. The December TAR indicated the resident's oxygen concentrator filter was last cleaned on 12/11/24 by RN 4. 5. During an observation on 12/12/24 at 9:27 a.m., Resident 61's bilateral oxygen concentrator filters were moderately coated with a white powdery substance. The record for Resident 61 was reviewed on 12/17/24 at 10:59 a.m. The resident's diagnoses included, but were not limited to, emphysema, personal history of transient ischemic attack and cerebral infarction, paranoid schizophrenia, anxiety disorder, and a personal history of venous			

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	thrombosis and embolism. The physician's order, dated 1/1/24, indicated to administer O2 at 2 liters for O2 saturations of less than 90 and/or shortness of air, every 12 hours as needed for hypoxia. The Annual MDS assessment, dated 8/5/24, indicated the resident was cognitively intact. The nurse's note, dated 8/31/24 at 11:25 a.m., indicated the resident complained of chest pain, which had started prior to the nurse taking over the hall at 11:00 a.m. The resident was administered nitroglycerin. When the nurse entered the room, the resident was nauseated, and his oxygen was on the floor. The nasal cannula was applied at 2 liters per minute. His vital signs were a blood pressure of 190/102 mg/dL, a pulse of 103 beats per minute, and oxygen saturations of 90% on 2 liters of oxygen. His respirations were at 20. The resident was yelling for help during the documentation by the nurse. Two nitroglycerin tablets were administered while the nurse was typing the note. The nurse's note, dated 9/25/24 at 11:30 a.m., indicated new orders were received to obtain a STAT (urgent) chest x-ray related to wheezing. The physician's order, dated 10/23/24, indicated to clean the oxygen concentrator filter every 7 days and PRN, every day shift on Wednesday. The care plan, reviewed 11/19/24, indicated the resident received oxygen therapy related to ineffective gas exchange and hypoxia. The interventions, dated 5/30/24 and revised 10/23/24, included, but was not limited to, 2 liters of O2 by nasal cannula, as needed routinely, for hypoxia			

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	and emphysema diagnoses; and dated 5/30/24 monitor the resident for signs or symptoms of respiratory distress and report to the MD, PRN. The December TAR indicated the resident's oxygen concentrator filter was last cleaned on 12/11/24 by LPN 5. The current Oxygen Therapy Using Concentrators policy included, but was not limited to, " ... Care and Maintenance a. Filters and maintenance are to be cleaned once a week...Perform hand hygiene and don gloves. ii. Remove filter...Rinse with running water until clean. iv. Squeeze water from filter...Dry with towel (cloth or paper)...Replace filter ..." 3.1-47(a)(6)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs Based on record review and interview, the facility failed to follow a physician's order related to hold parameters for insulin for 1 of 6 residents reviewed for Insulin. (Resident 39) Findings include: The clinical record for Resident 39 was reviewed on 12/13/24 at 1:30 p.m.. A Quarterly MDS (Minimum Data Set) assessment, dated 12/6/2024, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, diabetes, hypertension, congestive heart failure, and cognitive communication deficit. The resident received insulin for 7 of 7 days during the review period. The current physician's order, with a start date of	F 0757	1) Resident 39 was not harmed by the alleged deficient practice. NP and family notified. Plan of care reviewed. 2) All residents that receive insulin are at risk to be affected. All residents that receive insulin administration record will be reviewed for the last 14 days to assure MD orders for insulin were followed. Any concerns will be addressed immediately with NP/MD/family notifications. 3) DON/Designee will educate the licensed nursing staff on physician orders policy, emphasizing on following insulin administration parameters and 5	01/20/2025

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	8/14/24, indicated the resident was to receive Insulin Aspart Injection Solution 30 units subcutaneously three times a day. The staff were to hold (not administer) the insulin if the resident's blood sugar was less than 150. The October, November, and December 2024 Electronic Administration Record/Electronic Treatment Administration Record (EMAR/ETAR) indicated the Resident received the insulin when their blood sugar was less than 150 on the following dates and times: - 10/01/24 at 12:00 p.m.., when the blood sugar was 101, - 10/01/24 at 16:00 p.m., when the blood sugar was 106, - 10/02/24 at 16:00 p.m., when the blood sugar was 132, - 10/03/24 at 12:00 p.m., when the blood sugar was 102, - 10/08/24 at 8:00 a.m., when the blood sugar was 139, - 10/09/24 at 12:00 p.m., when the blood sugar was 146, - 10/09/24 at 16:00 p.m., when the blood sugar was 130, - 10/10/24 at 08:00 a.m., when the blood sugar was 132, - 10/10/24 at 16:00 p.m., when the blood sugar was 135, - 10/15/24 at 8:00 a.m., when the blood sugar was 132, - 10/15/24 at 12:00 p.m., when the blood sugar was 105, - 10/15/24 at 16:00 p.m., when the blood sugar was 131, - 10/16/24 at 8:00 a.m., when the blood sugar was 113, - 10/16/24 at 16:00 a.m., when the blood sugar was		rights of medication administration. 4) DON/Designee will audit 5 residents a week x 4 weeks, 3 residents a week x 4 weeks, then 1 resident weekly x 4 weeks to validate insulin parameters were being followed per MD order. DON/Designee will report on audits monthly to the interdisciplinary team for 3 months during the QAPI Meeting. The IDT will determine if the audits are necessary to continue after 3 months with 100% compliance	

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	138, - 10/17/24 at 8:00 a.m., when the blood sugar was 113, - 10/19/24 at 12:00 p.m., when the blood sugar was 117, - 10/22/24 at 8:00 a.m., when the blood sugar was 124, - 10/22/24 at 12:00 p.m., when the blood sugar was 119, - 10/22/24 at 16:00 p.m., when the blood sugar was 140, - 10/24/24 at 8:00 a.m., when the blood sugar was 111, - 10/24/24 at 12:00 p.m., when the blood sugar was 117, - 10/24/24 at 16:00 a.m., when the blood sugar was 146, - 10/28/24 at 8:00 p.m., when the blood sugar was 108, - 10/29/24 at 12:00 p.m., when the blood sugar was 119, - 10/30/24 at 8:00 a.m., when the blood sugar was 123, - 10/30/24 at 12:00 p.m., when the blood sugar was 123, - 10/31/24 at 8:00 a.m., when the blood sugar was 124, - 11/05/24 at 08:00 a.m., when the blood sugar was 130, - 11/05/24 at 12:00 p.m. when the blood sugar was 101, - 11/06/24 at 8:00 a.m., when the blood sugar was 113, - 11/06/24 at 12:00 a.m., when the blood sugar was 103, - 11/07/24 at 8:00 a.m., when the blood sugar was 103, - 11/09/24 at 12:00 a.m., when the blood sugar was 135, - 11/13/24 at 12:00 p.m., when the blood sugar was			

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	105, - 11/20/24 at 16:00 p.m., when the blood sugar was 126, - 11/21/24 at 8:00 a.m., when the blood sugar was 118, - 11/21/24 at 12:00 a.m., when the blood sugar was 134, - 11/26/24 at 16:00 a.m. when the blood sugar was 142, -11/27/24 at 8:00 a.m., when the blood sugar was 113, -11/27/24 at 12:00 p.m., when the blood sugar was 108, -12/03/24 at 12:00 p.m., when the blood sugar was 116, and -12/03/24 at 16:00 p.m., when the blood sugar was 101. During an interview on 12/17/24 at 1:33 p.m., Licensed Practical Nurse (LPN) 11 indicated generally, all insulins here had parameters. If a resident had a hold parameter on an insulin, she would obtain the blood sugar and hold the medication per the physician's order. She found no reason to give insulin outside of the physician's ordered parameters. The Nurse Practitioner (NP) or physician should be notified immediately if blood glucose values were below the critical low or high range. The care plan, dated 2/22/2022, indicated the resident had diabetes type II with hyperglycemia, neuropathy, neurologic complication. The interventions, dated 2/22/2022, included, but were not limited to, administer insulin injections per physician's orders, obtain blood sugars per orders, and report abnormal findings to medical provider, resident/resident representative. The current policy included, titled "Medication			

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	Administration", was provided by the AIT (Administer in Training) on 12/18/24 at 10:52 a.m.. The policy indicated, " ...Administer medication only as prescribed by the provider ...Observe the "five rights" in giving each medication that it is the right resident, the right time, the right medicine, the right dose, the right route ..." 3.1-48(a)(6)			
F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services Based on record review and interview, the facility failed to follow physician's order with obtaining laboratory services for 2 of 5 residents reviewed for laboratory services. (Residents 25 and 14) Findings include: 1. The clinical record for Resident 25 was reviewed on 12/16/24 at 11:32 a.m. A Quarterly Minimum Data Set (MDS) assessment, dated 12/4/24, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, seizures, hypertension, anxiety, depression, and bipolar. A current physician's order, with a start date of 7/1/24, indicated the staff were to obtain a Complete Blood Count (CBC), Complete Metabolic Panel (CMP), Oxcarbazepine level, Keppra level, A1C (average blood sugar over three months, thyroid stimulating hormone (TSH), Vitamin D level, and Vitamin B-12 level every three months, starting on 7/1/24. The resident's record lacked documentation of a CMP, A1C, TSH, Vitamin D, and Vitamin B-12 in July 2024.	F 0770	1) Resident 14 and 25 were not harmed by the alleged deficient practice. Resident 14 MD was notified and new order given for PTINR, was in normal limits, plan of care was reviewed. Resident 25, NP made aware, new order received to obtain labs, care plan reviewed. 2) All residents that have laboratory orders have the risk to be affected. All laboratory orders for the last 30 days will be reviewed to assure labs were obtained and addressed. 3) DON/Designee will educate the licensed nursing staff and IDT team on laboratory services policy and procedure. 4) DON/Designee will audit 10 residents a week x 4 weeks, 5 residents a week x 4 weeks, then 3 residents a week x 4 weeks to validate all laboratory orders were obtained and addressed . DON/Designee will report on audits monthly to the	01/20/2025

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	The resident's record lacked documentation of a CBC, CMP, Oxcarbazepine level, Keppra level, A1C, TSH, Vitamin D level, and Vitamin B-12 level, in October 2024. An open-ended physician's order with a start date of 11/13/24, indicated the staff were to obtain a CBC, CMP, Oxcarbazepine level, Keppra level, A1C, TSH, Vitamin D level, and Vitamin B-12 level every three months, starting on 11/13/24. The resident's record lacked documentation of an Oxcarbazepine level in November 2024. During an interview on 12/18/24 at 9:54 a.m., Licensed Practical Nurse (LPN) 10 indicated when the Nurse Practitioner ordered labs (laboratory tests) for a resident, she would input the order herself. The nurse would be alerted that there was a pending order for the residents. The nurse would have to transcribe the labs into the lab courier system for them to come and obtain the laboratory tests. The lab company would come Monday through Friday to obtain labs. Once the labs were obtained and taken to the lab, the lab company would post the results in the resident's clinical record and send them a fax. If the labs were urgent, then the facility nurse would call the Nurse Practitioner. If they were not urgent, she would review them on her next visit. The Nurse Practitioner was in the facility Monday through Friday. The labs were obtained based on how the nurse put the order into the lab companies' system. During an interview on 12/18/24 at 11:13 a.m., the Director of Nursing (DON) indicated the resident's labs were not completed per the physician's order. There were no labs obtained in October and a new		interdisciplinary team for 3 months during the QAPI Meeting. The IDT will determine if the audits are necessary to continue after 3 months with 100% compliance.	

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	order was placed in November. 2. The clinical record for Resident 14 was reviewed on 12/13/24 at 10:05 a.m. A Significant Change Minimum Data Set (MDS) assessment, dated 9/29/24, indicated the resident was cognitively intact. The residents' diagnoses included, but were not limited to, cardiorespiratory conditions, atrial fibrillation, heart failure, and hypertension. The resident had received an anticoagulant during the assessment review period. An open-ended physician order, with a start date of 9/21/24, indicated the resident was to receive Warfarin (Coumadin, a blood thinning medication) 2 milligrams (mg), on Tuesday, Wednesday, Saturday, and Sunday for arterial fibrillation. An open-ended physician's order, with a start date of 9/21/24, indicated the resident was to receive Coumadin 2.5 mg, on Monday, Thursday, and Friday for arterial fibrillation. A Progress Note, dated 11/8/24 at 2:11 P.M., indicated the resident's physician was notified of the International Normalized Ratio (INR) results. A new order was obtained for Coumadin 2 mg, every day and the resident's INR was to be rechecked on 11/15/24. The resident had an INR level drawn on 11/22/24. The clinical record lacked indication that the physician was notified of the result, nor was there an order in place for another INR until 12/13/24. The Coumadin Anticoagulation Record, indicated the following: - 11/8/24, new dose of 2 mg daily, and recheck INR on 11/22/24,			

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	- 11/22/24, no change in dose, and recheck INR on 12/16/24. During an interview on 12/13/24 at 9:57 A.M., Licensed Practical Nurse (LPN) 9 indicated if a resident received Coumadin and had to get an INR level drawn, then there should be an order for that to be obtained. The INR result should be reviewed by the physician before the next scheduled dose of the medication. During an interview on 12/13/24 at 10:17 A.M., the Director of Nursing (DON) indicated the resident's coumadin order didn't get changed on 11/8/24 and the order and INR order should have been confirmed with the physician on 11/22/24. The current, undated, facility policy titled, "Warfarin Monitoring" was provided by the DON on 12/17/24 at 1:20 P.M. The policy indicated, "...The prescriber/physician will provide an order for INR monitoring for warfarin use...The facility will have an established communication method between the facility and the prescriber/physician for monitoring residents on the drug Warfarin...The nurse will update the log with new INR values, and adjusted doses as the medical order changes and lab values are known...The nurse will change the eMAR [Electronic Medication Administration Record] to reflect the new dose of Warfarin....The nurse will discontinue the previous dose of Warfarin in eMAR..." The current, undated, facility policy, titled "Laboratory and Radiological Services and Results Reporting", was provided by the DON on 12/18/24 at 11:50 a.m. The policy indicated, "...The facility will secure laboratory and radiological services that meet the needs of the resident population served..."			

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	12/18/2024

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

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	3.1-49(a)			