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	01/03/2025

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/03/25 Facility Number: 010597 Provider Number: 155657 AIM Number: 200204440 At this Emergency Preparedness survey, Harrison Healthcare Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has a capacity of 92 certified beds and had a census of 77 at the time of this visit. Quality Review completed on 01/07/25	E 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 survey conducted on January 3, 2025. Please accept this plan of correction as the provider's credible allegation of compliance. The facility would like to respectfully request a desk review.Sandra Pace , HFA	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/03/25 Facility Number: 010597 Provider Number: 155657 AIM Number: 200204440 At this Life Safety Code survey, Harrison Healthcare Center was found not in compliance	K 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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sandra Pace	HFA	01/24/2025

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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	with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 92 and had a census of 77 at the time of this survey. At the time of this survey the facility was experiencing a COVID 19 outbreak and had 29 known residents with the virus. Resident Rooms on the 100 Hall and COVID positive sections on the 200, 300 and 400 hall were not part of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. The facility has one detached storage building which was not sprinklered. Quality Review completed on 01/07/25		cited during the survey conducted on January 3, 2025. Please accept this plan of correction as the provider's credible allegation of compliance. The facility would like to respectfully request a desk review.Sandra Pace , HFA	
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other Based on observation and interview, the facility failed to maintain delayed egress systems of 1 exterior doors per Section 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect over 20 residents.	K 0100	STEP 1 Corrective action for the residents found to have been affected by the deficient practice: No residents were harmed by the alleged deficient practice. STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient	01/24/2025

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	Findings include: Based on observations and interviews during a facility tour with the Executive Director (ED) and Maintenance Director (MD) on 01/03/25 between 11:50 a.m. and 2:00 P.M., the exit door from the dining area into the courtyard had a 15 second delayed egress feature which did operate when tested. However, resetting the delayed egress feature required the disassembly of the keypad and manipulation from within the electronic keypad which took considerable time. The MD stated that in order to reset the door the keypad had to be taken apart and that this situation had existed for awhile and forewarned the surveyor that this would happen if we tested the door. The keypad feature, obvious to the public, was not functioning properly. The MD stated that the facilities contractor would need to replace the keypad. This finding was reviewed with the Director of Plant Operation and Administrator at the time of discovery and again at the exit conference at 12:30 p.m. 3.1-19(b)		practice: The door panel was replaced by safe care on January 10, 2025 and validated as functioning properly. STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:The ED/Designee held an in-service with facility staff on K-100 as it relates to insuring there is no delayed egress of any exterior door and all panels are functioning properly. STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:The Maintenance Director /Designee will observe 5 exterior doors week x 4 weeks, then 3 exterior doors a week x 4 weeks, then 1 exterior door x 4 weeks for no less than 3 months and compliance is maintained to ensure there is no delayed egress of any exterior door and all panels are functioning properly.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Based on observation and Interview, the facility failed to ensure 2 of over 6 delayed egress locking arrangements were installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following	K 0222	K222 STEP 1 Corrective action for the residents found to have been affected by the deficient practice:No residents were harmed by the alleged deficient practice. STEP 2 Corrective action taken for those residents having the potential to be affected by the	01/24/2025

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	conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect 20 residents and 4 staff. Findings include: Based on observations and interviews during a facility tour with the Executive Director (ED) and Maintenance Director (MD) on 01/03/25 between 11:50 a.m. and 2:00 P.M., (1) exit door to the outside from the Laundry and the (2) Kitchen Exit to the outside, each equipped with a 15 second delayed egress, failed to activate and function properly. When the exit doors were tested the irreversible process to release the lock was not initiated. Based on interview at the time of observation, the MD was unable to activate the delay egress. The MD stated the delayed egress was working when tested just a few days prior to the survey but is not working at the time of the survey and will need to be repaired. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference with each present. 3.1-19(b)		same deficient practice:The 2 doors we repaired by safe care on January 10, 2025 and validated as working properly. STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:The ED/Designee held an in-service with facility staff on K-222 as it relates to insuring there is no delayed egress doors and the facility process for monitoring of delayed egress. STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:The Maintenance Director /Designee will audit 3 delayed egress doors week x 4 weeks, then 2 delayed egress doors a week x 4 weeks, then 1 delayed egress door x 4 weeks for no less than 3 months and compliance is maintained to ensure no impediment to closing or latching.	
K 0293 SS=E	NFPA 101 Exit Signage			

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Bldg. 01	Based on observation and interview, the facility failed to ensure 1 of 1 courtyard doors to the outside of the facility were not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect 15 residents. Findings include: Based on observations and interviews during a facility tour with the Executive Director (ED) and Maintenance Director (MD) on 01/03/25 between 11:50 a.m. and 2:00 P.M., the "This is not an exit" sign was missing to the enclosed courtyard which had only one door. Based on interview at the time of the observations, the MD was able to locate the sign which read "This is not an exit" on the nearby window ledge and stated that the glue/adhesive on the back of the sign appeared to be missing. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference with each present. 3.1-19(b)	K 0293	STEP 1 Corrective action for the residents found to have been affected by the deficient practice: No residents were harmed by the alleged deficient practice.STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:Signage was placed on the door stating NOT AN EXIT on January 9, 2025.STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:The ED/Designee held an in-service with facility staff on K-293 as it relates to insuring there is the correct signage at all doors leading outside of the facility. STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:The Maintenance Director /Designee will audit 3 exit doors week x 4 weeks, then 2 exit doors a week x 4 weeks, then 1 exit door x 4 weeks for no less than 3 months and compliance is maintained to ensure proper signage is in place.	01/24/2025
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to provide an approved method for	K 0324	STEP 1 Corrective action for the residents found to have been	01/24/2025

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	returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2* Cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 The fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 An approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice affected 6 staff. Findings include: Based on observations and interview during a facility tour with the Executive Director (ED) and Maintenance Director (MD) on 01/03/25 between 11:50 a.m. and 2:00 P.M., the (1) 6 burner wheeled gas range and (2) flat griddle which were located on the cooking line under the hood in the kitchen were not provided with an approved method that would ensure that the appliances are returned to an approved design location after being moved for maintenance and cleaning. Based on interview with the MD, the facility in the past had used a blue plate which was affixed to the floor to locate		affected by the deficient practice: No residents were harmed by the alleged deficient practice. STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:Approved devices to ensure appliances are returned to appropriate location for proper coverage of system placed on January 10, 2025. STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:The ED/Designee held an in-service with facility staff on K-324 as it relates to insuring approved devices in place to ensure appropriation for proper coverage of system. STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:The Maintenance Director /Designee will audit devices weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly for no less than 3 months and compliance is maintained to ensure no impediment to closing or latching.	

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	the wheels. The blue "U" shaped plate was not attached to the floor and had been knocked under the appliance. The MD was able to reach under and retrieve it. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference with each present. 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 2 staff. Findings include: Based on observations and interviews during a facility tour with the Executive Director (ED) and Maintenance Director (MD) on 01/03/25 between 11:50 a.m. and 2:00 P.M., the corridor door to the Scale Room, equipped with a self-closing device, failed to close and latch positively into the door frame. Based on interview at the time of the observations, the MD agreed the aforementioned corridor door did not close and latch into the door frame. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference with each present. 3.1-19(b)	K 0363	STEP 1 Corrective action for the residents found to have been affected by the deficient practice: No residents were harmed by the alleged deficient practice. STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice: The corridor door was adjusted to ensure it closed properly on January 9, 2025. STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:The ED/Designee held an in-service with facility staff on K-363 as it relates to insuring the corridor door are able to close completely on demand without any manipulation to ensure it closes. STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:The	01/24/2025

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			Maintenance Director /Designee will audit 3 delayed egress doors week x 4 weeks, then 2 delayed egress doors a week x 4 weeks, then 1 delayed egress door x 4 weeks for no less than 3 months and compliance is maintained to ensure no impediment to closing or latching.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Based on observation and interview; the facility failed to ensure 1 of 1 smoking area was maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect 6 staff. Findings include: Based on observations and interviews during a facility tour with the Executive Director (ED) and Maintenance Director (MD) on 01/03/25 between 11:50 a.m. and 2:00 P.M., near the staff smoking area outside the Laundry Exit there were over 30-40 cigarette butts disposed on the ground in and around the building exit. Based on interview at the time of observations, the MD concluded there were over 30-40 cigarette butts on the ground in the aforementioned location. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference with each present. 3.1-19(b)	K 0741	STEP 1 Corrective action for the residents found to have been affected by the deficient practice: No residents were harmed by the alleged deficient practice. STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:No smoking signs placed in around exit door near Laundry exit on January 9, 2025. Smoking area marked for staff and noncombustible containers placed in correct area on January 9, 2025. STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:The ED/Designee held an in-service with facility staff on K-741 as it relates to insuring the staff are using an appropriate area for smoking and disposing of cigarette butts correctly. Staff will be educated on smoking policy.	01/24/2025

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			STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:The Maintenance Director /Designee will audit 1 smoking area 4 days week x 4 weeks, then 2 days a week x 4 weeks, then 1 day a week x 4 weeks for no less than 3 months and compliance is maintained to ensure no impediment to closing or latching.	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on records review, observation, and interview, the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical	K 0921	STEP 1 Corrective action for the residents found to have been affected by the deficient practice: No residents were harmed by the alleged deficient practice. STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice: STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:The ED/Designee held an in-service with MD on K-921 as it relates to insuring there is testing on any patient -care related electrical equipment after repairs are made and documented after testing is completed STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:The ED	01/24/2025

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	equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice affects all residents. Findings include: Based on records review, interview and facility tour with the Executive Director (ED) and Maintenance Director (MD) on 01/03/25 between 9:50 a.m. and 11:50 a.m., no documentation was available for review for the testing of the PCREE in use throughout the facility, as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. Observation during the building tour revealed that the facility provided electric beds for all residents. The ED stated that PCREE such as nebulizers, oxygen concentrators, vital signs monitors, and other electrical medical equipment was present and in use at the facility. Both the ED and MD stated that the facility was not aware that the PCREE was required to be tested. During a telephone call with the Regional Support Representative he stated that the facility does a monthly check to verify that electrical equipment in resident rooms is visually inspected, but no functional testing is currently being done for physical integrity, resistance, leakage current, or touch current tests. He stated that they did not have the equipment to conduct the aforementioned testing. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference with each present. 3.1-19(b)		/Designee will audit PCREE testing logs to ensure compliance is maintained to ensure the PCREE devices are safe to us for patient care.	