	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 155852	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/13/2024
	ROVIDER OR SUPPLIER ON SPRINGS HEALTH CAMPUS	871 PA	ADDRESS, CITY, STATE, ZIP COD CER DRIVE NW DON, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 0000				
Bldg. 00	This visit was for a Recertification and State Licensure Survey and the investigation of Complaint IN00428084. This visit included a State Residential Licensure Survey. Complaint IN00428084 - Federal/State deficiency	F 0000		
	related to the allegation is cited at F565			
	Survey dates: February 7, 8, 9, 12, and 13, 2024			
	Facility number: 013702 Provider number: 155852 AIM number: 300018569			
	Census Bed Type: SNF: 29 SNF/NF: 22 Residential: 31 Total: 82			
	Census Payor Type: Medicare: 22 Medicaid: 16 Other: 13 Total: 51			
	This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.			
	Quality review completed on February 15, 2024.			
F 0565 SS=E Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Ryan Morton Executive Director 03/04/2024

Any defiency statement 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 disclodays 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) N		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION (X3) DA'				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETE	COMPLETED	
		155852	B. WING		02/13/202	24	
			GERRI	ET ADDRESS SITUATION OF THE SID SOD			
NAME OF F	PROVIDER OR SUPPLIEF	₹		ET ADDRESS, CITY, STATE, ZIP COD			
LIADDICA		I TH CAMPILE		PACER DRIVE NW			
ПАККІЗ	ON SPRINGS HEAI	LTH CAMPUS	COR	RYDON, IN 47112			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX		BE CO	MPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	family group, if on	e exists, with private space;					
	and take reasonal	ble steps, with the approval					
	of the group, to m	ake residents and family					
		of upcoming meetings in a					
	timely manner.						
	1 ' '	or other guests may attend					
	resident group or family group meetings only						
	at the respective (
	(iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is						
	responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a						
	1 ' '						
		group and act promptly					
		es and recommendations of erning issues of resident					
	care and life in the	_					
		ust be able to demonstrate					
	1 ' '	d rationale for such					
	response.	d rationale for Such					
	1	ot be construed to mean					
	that the facility mu						
	1	ery request of the resident					
	or family group.	.,,					
	§483.10(f)(6) The	resident has a right to					
	participate in fami	-					
	§483.10(f)(7) The	resident has a right to have					
	family member(s)	-					
	representative(s)	meet in the facility with the					
	families or resider	nt representative(s) of other					
	residents in the fa						
		view and interview, the facility	F 0565	This plan of correction is to	serve 03	3/01/2024	
		ely respond to and act upon		as Harrison Springs credible	e		
		rom the Resident Council		allegation of compliance.			
	_	cient practice had the potential		Submission of this plan of			
	to affect the 51 hear	Ith care residents currently		correction does not constitu	te an		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 02/13/2024 155852 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 871 PACER DRIVE NW HARRISON SPRINGS HEALTH CAMPUS CORYDON. IN 47112 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE residing in the facility. admission by Harrison Springs or its management company that the Findings Include: allegations contained in the survey report is a true and accurate The resident council meeting minutes, dated portraval of the provision of nursing 9/6/23, indicated residents voiced concerns care and other services in this related to dining services. The dining times were facility, nor does this submission inconsistent, and they were supposed to serve constitute an agreement or lunch at 11:30 a.m., and dinner ran late. There was admission of the survey sloppy food presentation, too many peas and allegations. The facility hereby carrots, and more variety was desired. Residents maintains it is in substantial had concerns about staff transportating them compliance with the requirements back to their rooms and they wanted rolls. of participation for comprehensive health care facilities. Attached you The response, as documented by the Dietary will find our plan of correction for Manager on 9/8/23, indicated the concern could Harrison Springs Health campus have been a one time occurrence. Dinner started for our annual survey conducted on time every day. Lunch was at 11:30 a.m. and on February 13, 2024. We initiated dinner was at 4:30 p.m. Some residents requested immediate interventions when their meals early and that was their right. If the concerns were identified on this meal was ready, they would serve them. date and began re-education for staff as well. We respectfully The response did not address the concerns with request paper/desk review for this the presentation, transport back to the resident's plan of correction. If you need any rooms, or food concerns. information or paperwork, please contact me at (812) 738-0317. The resident council meeting minutes, dated 10/6/23, indicated the residents voiced concerns Sincerely, related to dining services, which indicated lunch did not start until noon. Mealtimes were inconsistent, and it was still hard to find someone to transport residents back to their rooms after Ryan Morton ED meals. Harrison Springs Health Campus Ryan.Morton@Harrisonspringshc. The response, as documented by the Dietary com Manager on 10/8/23, indicated lunch had been very consistent on a specific day. A lot of residents made special requests and service fell behind about 10 minutes. The Dietary Manager F 565 Resident/Family Group did not agree that this situation happened. and Response

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155852	B. WING		02/13/2024	
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	3		CER DRIVE NW		
HARRIS	ON SPRINGS HEAI	LTH CAMPUS		OON, IN 47112		
(X4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIE		ID	ı	(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
TAG	·	R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE	
1710	REGUENTORT OF	KEEG IDENTIFIED IN ORDER THON	1710	It is the practice of this provide	5.112	
	The response did no	ot address the concerns		provide care/services for highe		
	_	sport back to the resident's		well-being in accordance with		
	rooms.			State and Federal law.		
				1: What corrective action(s)	will	
	The resident counci	il meeting minutes, dated		be accomplished for those		
		residents voiced concerns		residents found to have		
		rvices. The room trays were		affected by the deficient		
		od was not an accurate		practice?		
	temperature.			Meal services include food	d	
	The response, as documented by the Dietary Manager on 11/7/23, indicated room trays were served every day at 8:00 a.m., 12:00 p.m., and 5:00 p.m. at their posted time. It did not vary often.			delivery times, transporting of	_	
				residents before and after mea	al	
				service.		
				DFS continues to meet wi	th	
				residents during "Chef Circle"		
		off 5 or 10 minutes because of		weekly, this meeting allows		
	special orders by re	esidents that were not on the		residents to discuss what men	u	
		common for residents to order		items residents want on the m	enu.	
		linner time, which slowed		DFS/Dietary staff to condu	uct	
	service down.			temperature checks on food d		
				and for every meal.		
	The response did no	ot address the concerns		Dietary roll the silverware	per	
	relating to staff tran	sport back to the resident		each resident's preference		
	rooms or food temp	peratures.		Gordon Food Service due	to	
				check proper operation of dish	1	
	The resident counci	il meeting minutes, dated		machine 2-28-24.		
	12/7/23, indicated r	residents voiced concerns		Dish Machine drain filter to	o be	
	_	rvices. They were requesting		cleaned twice daily to prevent		
		olled and placed at the steam		dishes from being dirty or gritty	y.	
	-	l, not set out on the tables.		DFS provided education to	0	
		g out dirty and gritty. There		resident council members		
		back after meals. One resident		regarding starch build up caus	_	
		if she didn't get big enough		dark spots in the potatoes. DF		
	_	dents were tired of getting the		provided education to Dietary	staff	
		ng chicken and burgers, over		on how to identify spoiled		
		s wanted staff to read their		potatoes.		
		ers. Food was still cold and not		DFS provided education to		
	being prepared prop	perly.		cooks regarding cooking bean		
				DFS will ensure beans are coo	oked	
	The response, as do	ocumented by the Dietary		to resident's preference.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 02/13/2024 155852 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 871 PACER DRIVE NW HARRISON SPRINGS HEALTH CAMPUS CORYDON, IN 47112 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Manager on 12/19/23, indicated he followed the DFS provided education to all company's policies on how they should set the cooks regarding following recipes tables. They would not set the tables in the to avoid over/under salting of food. evening because the silverware sat on the tables Dietary to follow menu all night and the residents were afraid the choices for each resident. When silverware would be contaminated, so he honored passing meal trays, staff members that request. Only one resident wanted the are to ensure that selective menu silverware to be rolled all day long, but he choices are provided. explained to her it was not the policy. The resident DSS conducted interviews who requested larger portions could have with all residents with a BIMS of 8 whatever she wanted and did. She ate very large or greater with updates to care portions every meal which was why she had a plan for any resident that did not considerable weight gain and there was some wish to have any staff in their confusion there. He would mention the food rooms during breakfast. temperatures in the next chef circle. He recently Residents provided deep had a chef circle, and no residents voiced any cleaning schedule by concerns about the food to him. Environmental manager. Education provided to The response did not address the concerns assisted living resident council regarding dirty dishes, repetitive menus, or regarding regulations for staffing reading menus and orders. on assisted living and made aware that there are staff available 24 The resident council meeting minutes, dated hours/dav. 1/5/24, indicated residents voiced concerns with Education provided to all staff dining services. The dining plates were cold they to leave resident bathroom door needed to be heated up before serving. The ajar at night for easy access. dishes were gritty. Potatoes were coming out Residents participate in partially rotten. Chili beans were too hard, and too selective menu options with much salt was being used in meals. education provided to residents with diet restrictions. The response, as documented by the Social ED provided information Services director on 1/5/24, indicated dietary was during resident council meeting to notified of the concerns and dishes were to be the resident council that the gathered and washed nightly. residents may purchase life alerts if they wish to. The response did not address the concerns any DHS provided education to further, and did not address cold plates, the clinical staff regarding changing of partially rotten potatoes, chili beans or too much bed linens on shower days and salt. prn soilage. DHS provided education to

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155852	B. W	ING		02/13/2024	
		l .		STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8			CER DRIVE NW		
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HANKIS	JIN OF ININGS FIEAL	_ III OAMI OO		CORTL	· · · · · · · · · · · · · · · · · · ·		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES.)		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE
		eeting minutes, dated 2/2/24,			clinical staff regarding passing		
		voiced concerns with dietary			fresh ice water each shift. DH		
	services. They were not getting what they circled				provided education to clinical		
		resident had to wait a long			regarding making residents be		
	time to get back to their room.				those that wish to have their b	eds	
					made daily prn.		
	-	cumented by the Social			DFS or designee to check		
		n 2/5/24, indicated staff were to			the snack drawers on assisted		
		re serving to make sure the			living and health campus to er	nsure	
	· ·	and staff were to make sure			proper number of snacks are		
		n back to their rooms after meal			adequate.		
	service.				DHS provided education to		
	TEL C 111 1.1				nurses and certified medicatio		
		ot provide any documentation			aides regarding providing fres	h ice	
	-	roughly investigated the			water with medications.		
		nd actions taken to correct			DHS provided education t		
	them.				clinical staff regarding passing		
	D	2/12/24 + 0.25 + 4			menu tickets daily to residents	S.	
	-	on 2/13/24 at 9:35 a.m., the			Upon admission, all new		
		indicated he was the grievance			residents are assigned a		
		final resolutions. When the			department leader to ensure		
		ought up the Activities			appropriate acclimation to can	npus	
		n up and they distributed them nent had a grievance and the			for 5 days after admission.		
	•	•			ED attending all resident		
	_	ddressed the issue. He would k to the residents and	1		council meetings.	to all	
		concerns. They tried to			DHS provided education t	เบลแ	
		s. He would follow up on them.			staff regarding knocking on	tho	
		ne repetitive concerns on food.	1		resident's doors and allowing resident to invite staff into their		
		ain individual who voiced the				ı	
		ng taken back to their rooms,			room. DFS provided education t	0	
		s the board. Some things were			dietary staff regarding adequa		
		out he didn't know why it was			portions of food to avoid too	ıG	
	getting brought up a				large/small portions.		
		ts. He had stayed on evening			DHS provided education t	to	
		but he didn't have an audit			clinical staff regarding leaving		
		as there. As far as the			lighting on per resident prefere	ance	
		he read them, and he did the			when leaving the resident's ro		
	_	ed off on them, but did not do			DFS provided education	OIII.	
	_	t to address the concerns			during resident council and du	ring	

PRINTED: 03/06/2024 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155852 B. WING 02/13/2024

NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
			871 PACER DRIVE NW			
HARRIS	ON SPRINGS HEALTH CAMPUS	CORYE	CORYDON, IN 47112			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	Ultimately it would come down to him. His		"chef circle" regarding the steam			
	expectation would be not to deflect the concern,		table for assisted living not in use			
	but to investigate the concern.		due to the residents requesting			
			multiple ala cart items.			
	During an interview on 2/13/24 at 9:59 a.m., the		DFS provided education to all			
	Activities Director indicated he conducted the		cooks regarding following recipes			
	meetings. Residents voiced concerns to him, and		to avoid over/under salting food.			
	he filled the concerns out. He reported the		DHS and nurses to monitor			
	concerns to the IDT (interdisciplinary team). One		the CRCA's lunch time and ensure			
	of the main concerns voiced was residents not		that the CRCA is back on the hall			
	being taken back to their rooms after meals. They		after the allotted time.			
	tried to approach those concerns by making		DHS provided education to			
	themselves available, but it was not good enough.		staff regarding notification to			
	As far as things being able to change immediately,		dietary department when a			
	that didn't happen, and it added fuel to the		resident is assisted to the dining			
	problem. Some things could not be fixed. It was		room. DFS provided education to			
	one specific resident who voiced the concerns		the dietary staff to monitor dining			
	about being taken back to her room, but other		room for the resident arrivals to			
	residents did agree it was a concern as well. The		allow for appropriate serving time.			
	meals were often late, the kitchen had been		All concerns were addressed with			
	struggling. Their times were never consistent, and		IDT team. Results of plan will be			
	he had observed that. Residents would wait for		communicated to key staff			
	food forever. They were often just waiting for		members as well as at Resident			
	their food, and he did not know what to say to		Council including Resident Council			
	them. It was an operation in the kitchen that		President.			
	stopped that from happening. They didn't come					
	back and tell the residents about the resolution		2: How other residents having			
	like they should. It usually waited until the next		the potential to be affected by			
	meeting. He did not get responses. When the new		the same deficient practice will			
	meeting would come up, he would ask if old		be identified and what			
	business had gotten better, because he didn't		corrective action will be taken?			
	know if anything got better unless the residents		All residents have the			
	told him.		potential to be affected by the			
			alleged deficient practice.			
	During an interview on 2/13/24 at 12:07 p.m., the		ED/designee reviewed all			
	Resident Council President indicated they did		areas: Nursing, Dietary,			
	have some continued concerns at the resident		Environmental and Admin with IDT			
	council minutes. The big issue was getting a		and key staff members as well as			
	resident back to their room after the meals. It was		at Resident Council including			
	just one resident, but there were others who did		Resident Council president.			

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FY7811

PRINTED: 03/06/2024 FORM APPROVED OMB NO. 0938-039

					02/13/	2024
NAME OF PROVIDER OR SUPPLIER HARRISON SPRINGS HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIE		8	71 PAC	DDRESS, CITY, STATE, ZIP COD CER DRIVE NW ON, IN 47112		
(EACH DEFICIENC		PRI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Œ	(X5) COMPLETION DATE
4. The facility will fresponding to a comwithout interruption brought the concern the person bringing that what happened make excuses for what was to correct problem their own being resolved, and stay department leader was concerns with the teeducate to prevent frequency the concern form us needed and will foll reporting the concern with the concern form us needed and will foll reporting the concern states.	follow these basic steps in applaint Listen to the concern Thank the person who to the staff Apologize to the concern and acknowledge is not to our standards Not they or how this has happened to the problem Make the problem Make the problem Make the strill investigate and discuss the am and will implement, or surther concerns The full document the resolution on ing an addendum when ow up with the person in to explain the resolution"	1.			1,	DATE
Survey. This visit in State Licensure Survey of Complaint IN0042 Complaint IN00428 the allegation is cite Survey dates: Febru Facility number: 013 Residential Census:	actuded a Recertification and vey and and the investigation 28084. 084 - State deficiency related to d at F0039 ary 7, 8, 9, 12, and 13, 2024 3702	R 0000				
	(EACH DEFICIENCE REGULATORY OR A. The facility will for responding to a common without interruption brought the concern the person bringing that what happened make excuses for will take steps to correct problem their own being resolved, and stay department leader word concerns with the ten educate to prevent for department leader with the concern form us needed and will follow reporting the concerns with the ten concerns with the concern form us needed and will follow reporting the concerns with the concerns with the concerns with the concerns with the ten concerns with the ten concern form us needed and will follow reporting the concerns with the concerns with the concerns with the ten concerns	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 4. The facility will follow these basic steps in responding to a complaint Listen to the concern without interruption Thank the person who brought the concern to the staff Apologize to the person bringing the concern and acknowledge that what happened is not to our standards Not make excuses for why or how this has happened Take steps to correct the problem Make the problem their own by following up to make sure it is resolved, and stays resolved 9. The department leader will investigate and discuss the concerns with the team and will implement, or educate to prevent further concerns The department leader will document the resolution on the concern form using an addendum when needed and will follow up with the person reporting the concern to explain the resolution"	4. 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This visit included a Recertification and State Licensure Survey and and the investigation of Complaint IN00428084 - State deficiency related to the allegation is cited at F0039 Survey dates: February 7, 8, 9, 12, and 13, 2024 Facility number: 013702 Residential Census: 31	4. The facility will follow these basic steps in responding to a complaint Listen to the concern without interruption Thank the person who brought the concern to the staff Apologize to the person bringing the concern and acknowledge that what happened is not to our standards Not make excuses for why or how this has happened Take steps to correct the problem Make the problem their own by following up to make sure it is resolved, and stays resolved 9. 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This visit included a Recertification and State Licensure Survey and and the investigation of Complaint IN00428084 - State deficiency related to the allegation is cited at F0039 Survey dates: February 7, 8, 9, 12, and 13, 2024 Facility number: 013702 Residential Census: 31	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION 4. The facility will follow these basic steps in responding to a complaint Listen to the concern without interruption Thank the person who brought the concern and acknowledge that what happened is not to our standards Not make excuses for why or how this has happened Take steps to correct the problem Make the problem their own by following up to make sure it is resolved, and stays resolved 9. 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PRINTED: 03/06/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155852	B. W	ING		02/13/	2024
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD 871 PACER DRIVE NW CORYDON, IN 47112			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE.	DATE
	accordance with 410	0 IAC 16.2-5.					
	Quality review com	pleted on February 15, 2024.					
R 0039	410 IAC 16.2-5-1.	2(n)					
	Residents' Rights-	Deficiency					
Bldg. 00		, throughout the period of					
		rievances to the facility staff					
		presentative of their choice,					
	_	ges in policy and procedure,					
and receive reasonable responses to their requests without fear of reprisal or interference.							
		riew and interview, the facility	R 0	020	This plan of correction is to se	n/o	03/01/2024
		ely respond to and act upon	K U	039	as Harrison Springs credible	100	03/01/2024
		om the Resident Council			allegation of compliance.		
		cient practice had the potential			Submission of this plan of		
	-	dents currently residing in the			correction does not constitute	an	
	facility.	Ç			admission by Harrison Springs		
	Findings include:				its management company that allegations contained in the su report is a true and accurate	t the	
	The resident counci	l meeting minutes, dated			portrayal of the provision of nu	ırsing	
		e residents voiced concerns			care and other services in this	•	
	related to dining ser	vices, which included			facility, nor does this submissi	on	
	mealtimes were con	fusing and they did not want			constitute an agreement or		
	staff coming into the	eir rooms at 7:00 a.m. for			admission of the survey		
	breakfast. There wa	s no response documented or			allegations. The facility hereby	/	
	signed off on by the	department head or the			maintains it is in substantial		
	Executive Director.				compliance with the requireme		
					of participation for comprehen		
		l meeting minutes, dated			health care facilities. Attached	-	
	10/4/23, indicated the	he following concerns:			will find our plan of correction		
	T 1 // 1				Harrison Springs Health camp		
	-	ping: Housekeeping did not			for our annual survey conduct		
		trash was left in the garbage			on February 13, 2024. We init		
		vanted a new copy of the deep			immediate interventions when		
	cleaning schedule.	s not enough aides, if the door			concerns were identified on the		
	_	hroom was open at night,			date and began re-education f staff as well. We respectfully	IOI	
	w me residence ball	moom was open at mgm,	1		j stati as well. We respectfully		

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PRINTED: 03/06/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155852		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 02/13/2024	
	PROVIDER OR SUPPLIER		871 PA	ADDRESS, CITY, STATE, ZIP COD ACER DRIVE NW DON, IN 47112	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
IAU	please leave it ajar to a please leave it ajar to bining services: the chicken dish for lun	For the resident's easy access. Here was no chicken in their ch, the serving sizes were too with colitis were complaining	TAU	request paper/desk review for plan of correction. If you need information or paperwork, ple contact me at (812) 738-0317	r this d any ase
	There was no respo	onse documented or signed off not head or the Executive the concerns.		Sincerely,	
	11/3/23, indicated the	l meeting minutes, dated he following concerns:		Ryan Morton ED Harrison Springs Health Cam Ryan.Morton@Harrisonspring com	•
	- Nursing: Residents wanted a life alert. There wasn't enough aides and they needed help to return after meals. They weren't getting fresh water, sheets were not being changed, and beds			F 565 Resident/Family Grou	p
	were not being mad 10:00 p.m. to 6:00 a -Dining services: re happened to the wee	e. There was no nurse from a.m. sidents wanted to know what ekly menu. The steam table		and Response It is the practice of this provid provide care/services for high well-being in accordance with	er to lest
	to be rolled. Everyth washed after every	naccurate. Silverware needed ning on the table needed to be meal. They could see dirt on temware. The snack drawer		State and Federal law. 1: What corrective action(s) be accomplished for those residents found to have affected by the deficient	will
	There was no respo	nse documented or signed off lead or the Executive Director erns.		practice? Meal services include for delivery times, transporting of residents before and after me	f
	12/8/23 indicated th	I meeting minutes, dated the following concerns: s no aides from 10:00 p.m. to		DFS continues to meet w residents during "Chef Circle" weekly, this meeting allows residents to discuss what me	,
	6:00 a.m. Sheets we They were not getti pass or shift change	ore still not getting changed. In g cold water at medication period aids used their enus were not passed. Aides		items residents want on the n DFS/Dietary staff to cond temperature checks on food of and for every meal. Dietary roll the silverware	nenu. duct daily,

State Form Event ID: FY7811 Facility ID: 013702 If continuation sheet Page 11 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155852	B. W	ING		02/13/2024	
		1		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			CER DRIVE NW		
HARRIS	ON SPRINGS HEAI	LTH CAMPUS			OON, IN 47112		
	Т		1		, T	1	are:
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG	communication was	R LSC IDENTIFYING INFORMATION	+	TAG			DATE
					each resident's preference		
		o one was helping new			Gordon Food Service due		
	residents get acclimated. They walked around looking lost and confused. Residents suggested a				check proper operation of dish	1	
	_				machine 2-28-24.		
		were requesting the Executive			Dish Machine drain filter t		
	_	ent at all resident council			cleaned twice daily to prevent		
	_	nocked and waited for a			dishes from being dirty or gritt	-	
	response before entering their rooms.				DFS provided education t	.0	
	- Dining services: residents were requesting for				resident council members		
	staff to wrapped silverware for every meal, and				regarding starch build up caus	-	
	dishes were not being cleaned properly. There				dark spots in the potatoes. DF		
	was no help getting back to their rooms. Portions				provided education to Dietary	staff	
	weren't large enough. They got the same food over and over. They were sick of chicken and				on how to identify spoiled		
					potatoes.		
		ed staff to read the diet and			DFS provided education t		
		ood was still cold and either			cooks regarding cooking bear		
	over or undercooke	d.			DFS will ensure beans are co	oked	
					to resident's preference.		
	_	nse documented or signed off			DFS provided education t		
		nead or the Executive Director			cooks regarding following reci	-	
	for any of the conce	erns.			to avoid over/under salting of	food.	
					Dietary to follow menu		
		Il meeting minutes, dated			choices for each resident. Wh		
	1/4/24, and indicate	ed the following concerns:			passing meal trays, staff mem		
					are to ensure that selective m	enu	
	-	ere still not being changed,			choices are provided.		
		with lights on. There was no			DSS conducted interview		
	_	n. to 6:00 a.m. One resident			with all residents with a BIMS		
	_	et help and had to call her			or greater with updates to care		
	family.				plan for any resident that did r	not	
	_	esidents voiced concerns with			wish to have any staff in their		
	~ ·	ing warmed up, gritty dishes,			rooms during breakfast.		
	-	am table kept up, the potatoes			Residents provided deep		
	_	ili beans were hard, and they			cleaning schedule by		
	wanted staff to water	ch the salt.			Environmental manager.		
					Education provided to		
	_	nse documented or signed off			assisted living resident counci	il	
	-	nead or the Executive Director			regarding regulations for staff	ing	
	for any of the conce	erns.			on assisted living and made a	ware	
					that there are staff available 2	<u> </u>	

State Form Event ID: FY7811 Facility ID: 013702 If continuation sheet Page 12 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. building <u>00</u>		COMPL	ETED
		155852	B. W	ING		02/13/	/2024
		<u> </u>		CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD CER DRIVE NW		
HARRIS	ON SPRINGS HEAI	I TH CAMPUS			OON, IN 47112		
	T				I		I
(X4) ID		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
TAG	 	il meeting minutes, dated		IAG			DATE
		sidents voiced the following			hours/day. Education provided to all	otoff	
		sidents voiced the following			to leave resident bathroom do		
	concerns:					OOI	
	Nursing: one resid	dent was changing her own			ajar at night for easy access.		
		ff after lunch period, and there			Residents participate in		
		-			selective menu options with	ıte.	
	was no aides to help the nurse Dining services: meals were not getting served				education provided to resider	แร	
	_	nears were not getting served mornings, they wanted more			with diet restrictions. ED provided information		
	staff on hand.	nornings, they wanted more			1	4 .	
	Staff Off flaffet.				during resident council meeting the resident council that the	ig to	
	There was no resne	onse documented or signed off				lorto	
	•	e			residents may purchase life a	IEI IS	
	by the department head or the Executive Director for any of the concerns.				if they wish to.	to.	
	for any of the concerns.				DHS provided education clinical staff regarding changi		
	During an interview on 2/13/24 at 9:35 a.m., the				bed linens on shower days ar	-	
	_	indicated he was the grievance			-	iu	
		final resolutions. When the			prn soilage. DHS provided education	to	
		ought up the Activities			clinical staff regarding passing		
		n up and they distributed them			fresh ice water each shift. DH	-	
		nent had a grievance and the					
	_	addressed the issue. He would			provided education to clinical regarding making residents b		
	_	ak to the residents and			those that wish to have their l		
		y concerns. They tried to			made daily prn.	Jeus	
		s. He would follow up on them.			DFS or designee to chec	l _r	
		ne repetitive concerns on food.			the snack drawers on assiste		
		ain individual who voiced the			living and health campus to e		
		ng taken back to their rooms,			proper number of snacks are	i isui c	
		s the board. Some things were			adequate.		
		out he didn't know why it was			DHS provided education	to	
		again. They had not			nurses and certified medication		
		ats. He had stayed on evening			aides regarding providing fres		
		but he didn't have an audit			water with medications.	311 IOC	
	· ·	as there. As far as the			DHS provided education	to	
		, he read them, and he did the			clinical staff regarding passing		
	_	ned off on them but did not do			menu tickets daily to resident	-	
	_	t to address the concerns.			Upon admission, all new	J.	
		come down to him. His			residents are assigned a		
	· ·	be not to deflect the concern,			department leader to ensure		
	but to investigate th				appropriate acclimation to cal	mnue	

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PRINTED: 03/06/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155852	JILDING	onstruction 00	(X3) DATE COMPL 02/13 /	ETED
NAME OF P	ROVIDER OR SUPPLIEF	R		ADDRESS, CITY, STATE, ZIP COD CER DRIVE NW		
HARRISO	ON SPRINGS HEAI	LTH CAMPUS		OON, IN 47112		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	During on intervious	v on 2/13/24 at 9:59 a.m., the		for 5 days after admission.		
	_	indicated he conducted the		ED attending all resident council meetings.		
		s voiced concerns to him, and		DHS provided education t	o all	
	-	ns out. He reported the		staff regarding knocking on	o ali	
		(interdisciplinary team). One		resident's doors and allowing	he	
		ns voiced was residents not		resident to invite staff into thei		
		their rooms after meals. They		room.		
	-	ose concerns by making		DFS provided education t	0	
	themselves availabl	le, but it was not good enough.		dietary staff regarding adequa		
	As far as things bei	ng able to change immediately,		portions of food to avoid too		
		and it added fuel to the		large/small portions.		
		ngs could not be fixed. It was		DHS provided education t	0	
		nt who voiced the concerns		clinical staff regarding leaving		
		eack to her room, but other		lighting on per resident prefere		
	_	it was a concern as well. The		when leaving the resident's ro	om.	
		te, the kitchen had been		DFS provided education		
		mes were never consistent, and		during resident council and du		
		nt. Residents would wait for		"chef circle" regarding the stea		
		were often just waiting for id not know what to say to		table for assisted living not in a		
		ration in the kitchen that		due to the residents requesting multiple ala cart items.	9	
	_	appening. They didn't come		DFS provided education to	o all	
		sidents about the resolution		cooks regarding following reci		
		usually waited until the next		to avoid over/under salting foo		
	-	t get responses. When the new		DHS and nurses to monitor		
		ne up, he would ask if old		the CRCA's lunch time and en		
	-	better, because he didn't		that the CRCA is back on the		
	know if anything go	ot better unless the residents		after the allotted time.		
	told him.			DHS provided education t	0	
				staff regarding notification to		
	_	v on 2/13/24 at 12:15 p.m., the		dietary department when a		
		indicated he could not find		resident is assisted to the dinii	•	
	_	sident council concerns. He		room. DFS provided education		
		nould be doing anything further		the dietary staff to monitor dini	-	
		cerns. He wrote out the		room for the resident arrivals t		
	heads, and he never	e a copy to the departments		allow for appropriate serving ti All concerns were addressed to		
	neads, and he never	got mem back.		IDT team. Results of plan will		
	During an interview	v on 2/13/24 at 1:01 p.m., the ED		communicated to key staff	ue	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155852	ì í	UILDING	ONSTRUCTION 00	(X3) DATE COMPL 02/13	ETED
NAME OF F	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP COD	•	
HARRIS	ON SPRINGS HEAI	_TH CAMPUS			CER DRIVE NW DON, IN 47112		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	4	TAG			DATE
		ey had addressed resident			members as well as at Reside		
	concerns, but could not locate any of the				Council including Resident Co		
	documentation.				President.		
	The most current R	esident Council policy			2: How other residents havi	na	
		ot limited to, " The resident			the potential to be affected by	_	
		d to promote the resident's			the same deficient practice v	-	
		d participate in resident			be identified and what	••••	
	groups in the Campus for the purpose of				corrective action will be take	n?	
	self-determination 7. The group facilitator will				All residents have the		
	determine the preva				potential to be affected by the		
	concern/recommendations voiced to determine				alleged deficient practice.		
	the appropriate follo	ow-up. 8. The group's			ED/designee reviewed al		
	grievances and recommendations will be brought				areas: Nursing, Dietary,		
	to the attention of the Executive Director who will				Environmental and Admin with		
		ns to the appropriate			and key staff members as we	ll as	
	-	or attention and response 8.2			at Resident Council including		
		ould be handled by following			Resident Council president.		
	-	n/grievance policy and			ED/designee to review		
	-	ns taken and/or considerations			Resident Concern Forms each	h	
		be reported back to the			business day to follow up per		
	Resident Council at	the next meeting"			policy.		
	The most current R	esident Concern policy			3: What measures will be pu into place or what systemic	ι	
		ot limited to, " Procedures 1.			changes will be made to		
	· ·	ovide an open and customer			ensure that the deficient		
		e for residents and their			practice does not recur?		
		entatives to voice concerns			The ED/designee will cond	uct	
	and problems with	the assurance that their			an in-service with department		
	concerns will be he	ard and acted upon. 2. The			heads and other staff on Resi	dent	
	•	mitted to the on-going			Concern Process Policy.		
		mployees on immediately			·As a measure of ongoing		
		esolving customer concerns			compliance, the ED/designee		
		follow these basic steps in			complete an audit of 5 resider		
		aplaint Listen to the concern			five times weekly for 4 weeks		
		n Thank the person who			then three times weekly for 4	4	
		to the staff Apologize to			weeks, then twice monthly for	ιWΟ	
		the concern and acknowledge is not to our standards Not			months, then monthly for 3		
		hy or how this has happened			months to ensure resident		
	make excuses for w	ny or now uns has happened			grievances or concerns are		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u> B. WING		COMPLETED 02/13/2024	
		155852	B. WING		02/13/2024	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 871 PACER DRIVE NW			
HARRISON SPRINGS HEALTH CAMPUS			CORYDON, IN 47112			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE	
	Take steps to correct the problem Make the problem their own by following up to make sure it is resolved, and stays resolved. 9. The				completed following Resident Concern Process Policy.	
	is resolved, and stays resolved 9. The department leader will investigate and discuss the concerns with the team and will implement, or educate to prevent further concerns The department leader will document the resolution on the concern form using an addendum when needed and will follow up with the person reporting the concern to explain the resolution" This citation relates to Complaint IN00428084.			4: How the corrective as will be monitored to ensideficient practice will not i.e. what quality assurant program will be put into For quality assurance, results of these audits will reviewed by the QA compoverseen by the ED, unticontinued compliance is maintained for 2 consecutive quarters. If threshold of 9 achieved, an action plan developed. 5. Date of completion: No 2024	sure the ot recur nace place? the ll be mittee, l lutive 10% is not will be	
				Completed by:		

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