STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155852	A. BUILDING 00 B. WING	01/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON SPRINGS HEALTH CAMPUS	871 PACER DRIVE NW CORYDON, IN 47112

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey and the investigation of Complaint IN00395706. Complaint IN00395706 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: January 19, 20, 23, 24, and 25, 2023 Facility number: 013702 Provider number: 155852 AIM number: 300018569 Census Bed Type: SNF: 29 SNF/NF: 23 Residential: 25 Total: 77 Census Payor Type: Medicare: 21 Medicaid: 22 Other: 9 Total: 52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 27, 2023.	F 0000	The submission of this plan of correction does not indicate an admission by Harrison Springs Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Harrison Springs Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment			

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

Lori Hess 02/10/2023

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	remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure fall interventions were implemented to prevent future falls for 1 of 4 residents reviewed for accidents. (Resident 21) Findings include: The clinical record for Resident 21 was reviewed on 1/20/23 at 1:06 p.m. The diagnoses included, but were not limited to, disc degeneration, lumbar region, dementia with other behavioral disturbance, unspecified fall, subsequent encounter, repeated falls, muscle weakness, difficulty in walking, need for assistance with personal care, wedge compression fracture of T5-T6 vertebra, multiple fractures of ribs, left side. The Quarterly MDS (Minimum Data Set) assessment, dated 11/25/22, indicated the resident was severely cognitively impaired, required extensive assistance of one staff member with transfers, and had one fall without injury since her last assessment. The care plan, initiated on 9/27/21 and last revised 12/27/22, indicated the resident was at risk for falling related to impaired mobility and medications. The nurse's note, dated 4/27/22 at 3:36 p.m., indicated the resident reported she had fallen in her room when transferring from the toilet and her foot slipped.	F 0689	1. Resident #21 had her care plan reviewed and updated with the appropriate intervention from the therapy recommendation. The identified resident did not suffer any adverse events from the alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. All residents with fall interventions recommended by the therapy team, have been implemented, reviewed, and added to the plan of care by the Interdisciplinary team (IDT) consisting of the Director of Health Services (DHS), Therapy Program Director, Director of Social Services, and MDS Coordinator. 3. The DHS provided education to the Therapy Program director and the therapy team regarding notification to the clinical team of any new interventions for care plan updates and placement of new devices. Also, the therapy team was provided education to place an order in matrixcare with every device that is recommended by therapy for fall interventions. The order will be reviewed by the IDT team during our clinical care meeting to ensure that the device	02/10/2023

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	The IDT (Interdisciplinary Team) note, dated 4/28/22 at 9:14 a.m., indicated the root cause of the resident's fall was her foot slipping during transfer. The immediate intervention was to provide the resident with education to use call light for assistance. The new intervention placed after discussion with the IDT was to have therapy evaluate and treat the resident as indicated for proper, safe transfer techniques. The therapy discharge note, dated 5/20/22, indicated the resident had an automatic brake system (ABS) placed to her wheelchair to lock brakes due to her inaccuracy with remembering to lock her brakes. The nurse's note, dated 5/21/22 at 6:06 p.m., indicated the resident was found sitting on the bathroom floor with her head against the wall by her shower bench. The resident appeared to have been toileting herself without her wheelchair or calling for assistance. The resident was sent to the hospital for evaluation. The nurse's note, dated 5/21/22 at 9:01 p.m., indicated the resident returned from the hospital with no evidence of acute breaks or fractures and orders for an antibiotic for a UTI (urinary tract infection). The IDT note, dated 5/23/22 at 9:14 a.m., indicated the resident was recently discharged from therapy and an ABS was placed to her wheelchair for safety due to the resident not locking the brakes when transferring. The root cause of the fall was forgetfulness, poor safety awareness, poor cognitive function, and the resident attempting to transfer without assisstive devices. The new intervention was for the resident to be assessed by the psychiatric consult team for increased		is care planned. The DHS and/or designee will perform audits on every fall to verify that any device recommended by therapy has an order and a care plan in place for the device. This audit will be completed daily during the clinical care meeting Monday through Friday for six months. 4. As a quality measure, the ED or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	behaviors, treatment for a UTI, and increased frequency of toileting to every 2 hours. The clinical record lacked documentation of the intervention of an ABS being added to the resident's care plan. The fall event report, dated 12/14/22 at 3:51 p.m., indicated the resident fell in her room while transferring herself. The personal inspection indicated the resident's wheelchair did not have anti-rollbacks in place. The IDT note, dated 12/15/22 at 9:20 a.m., indicated the resident had a non-injury fall with the root cause being the resident attempted to get into her wheelchair and due to cognitive deficits the resident did not lock her brakes. The new intervention placed was to provide the resident with anti-roll backs to her wheelchair. During an interview on 1/25/23 at 11:02 a.m., PTA (Physical Therapy Assistant) 13 indicated the ABS went on the back of the wheelchair and prevented it from tilting back. It was the same thing as anti-rollbacks. During an interview on 1/25/23 at 11:30 a.m., OT (Occupational Therapist) 14 indicated the ABS went on the back of the wheel chair and prevented it from tipping or rolling. It was the same as the anti-roll back system. If a resident was determined to need an ABS they would go to the Therapy Director and let her know and she would make the orders for it. During an interview on 1/25/23 at 11:37 a.m., the Therapy Director indicated the ABS was the same as the anti-roll back system. They used it a lot for a resident who forgot to put their brakes on their			

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	wheelchairs. When they stood it had a hydraulic system that when it feels the weight come off the seat it had two silver arms that put pressure on the rear wheels and kept it from moving. When they got up, their wheelchair auto locked. It was a great way to prevent falls for residents that had cognitive impairments who forgot to lock their wheelchairs. Typically they went to the meeting after any falls and if an ABS was needed she would let the IDT team know so they could put in an order and update the care plan for the intervention. Maintenance would install the system. When the resident fell on 12/15/22, it was a different wheelchair. She did not know what happened to the wheelchair she was in previously, and they had not assessed and determined her to not need the ABS any more. If the resident's wheelchair had changed for some reason the ABS should have been continued onto the new wheelchair. She did not know why it was not continued and based on the last time she saw her, the resident would benefit from the ABS. She had not changed the recommendation at any time. During an interview on 1/25/23 at 11:43 a.m., the DON (Director of Nursing) indicated if a therapy referral was the intervention and therapy suggested a new fall intervention, the intervention should have been put into place on the care plan. Why it did not happen with the ABS intervention she did not know. The Fall Management policy, provided on 1/23/23 at 1:30 p.m. by the Campus Support Clinical, included, but was not limited to, "... Purpose... mitigate fall risk factors and implement preventative measures... Procedure... 1... b. Care plan interventions should be implemented that address the resident's risk factors... 5. The resident care plan should be updated to reflect			

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	any new or change in interventions..." 3.1-45(a)(1)			
F 0745 SS=D Bldg. 00	483.40(d) Provision of Medically Related Social Service §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Based on observation, record review, and interview, the facility failed to ensure appropriate social services follow-up and monitoring for residents experiencing grief and poor adjustment to the facility for 2 of 3 residents reviewed for social services. (Residents 45 and 20) Findings include: 1. The clinical record for Resident 45 was reviewed on 1/20/22 at 11:10 a.m. The diagnoses included, but were not limited to, depression and generalized anxiety disorder. The nurse's note, dated 10/31/22 at 4:10 p.m., indicated the resident arrived to the facility by ambulance and was alert and oriented and able to make her needs known. The care plan, dated 11/1/22, indicated the resident demonstrated an altered mood due to recent life losses and admission to facility. The interventions included, but were not limited to, adjustment counseling contacts as needed, monitor for increased signs of depression with the PHQ-9 assessment as needed, observe the resident's adjustment to facility, rehab program, daily activity, and refer to psychiatric services as needed.	F 0745	1. Resident #45 and #20 now have follow up in the clinical record and are being monitored by the Director of Social Services (DSS) for grief and poor adjustment. Additionally, resident #45 has been referred to our behavioral health services, Team Health, for talk therapy with the Licensed Clinical Social Worker (LCSW.) Resident #20 declined behavioral health services, Team Health, from the LCSW and the Advanced Practice Registered Nurse (APRN.) No adverse effects noted by the alleged deficiency. 2. All residents have the potential to be affected from the alleged deficient practice. All residents residing at the campus had their clinical record reviewed by the Director of Health Services, Director of Social Services and no other residents were affected by the alleged deficient practice. 3. The Director of Health Services and clinical support provided re-education to the DSS on 2/7/23 regarding social service	02/10/2023

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	The Admission MDS (Minimum Data Set) assessment, dated 11/3/22, indicated the resident was cognitively intact and exhibited no rejection of care. The Social Service Comprehensive Note, dated 11/3/22, indicated the resident was seen for her initial first assessment. Her PhQ-9 (depression screening assessment) indicated the resident had moderate depression. She had a diagnosis of depression. She had no rejection of care behaviors in the past week. She signed the consent for psychiatric care services. She planned to discharge to assisted living if able. The Social History Observation dated 11/3/22, indicated the resident was a widow, had a history of mental illness and abuse. The nurse's note, dated 11/3/22 at 2:04 p.m., indicated the resident was refusing care that morning. The nurse's note, dated 11/29/22 at 12:55 p.m., indicated the resident was refusing to attend her doctor's appointment. The nurse's note, dated 12/3/22 at 8:53 a.m., indicated the resident had a trending weight loss. She had lost 10 pounds over 30 days and a request would be made for an appetite stimulant. The nurse's note, dated 12/6/22 at 10:35 a.m., indicated the resident was refusing her breakfast. The nurse and the CNA (Certified Nurse Aide) tried to talk the resident into eating, but she was refusing. The nurse's notes, on 12/6/22 at 10:40 a.m. and		documentation standards to assure that sufficient and appropriate social services are provided to meet the residents' needs and to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The DHS and/or designee will perform audits of all behavior/death of spouse/refusal of care, medications, and food/poor adjustment for new residents to the campus to ensure that the DSS has appropriately assessed and documented on psychosocial services daily Monday through Friday for 6 months. 4. As a quality measure, the ED or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	11:34 a.m., indicated the resident was refusing her medications and refused her lunch. Nursing staff would follow up with the NP (Nurse Practitioner) and the DON (Director of Nursing). The care plan, dated 12/7/22, indicated the resident had a history of a traumatic experience or event. The interventions included, but were not limited to, assist the resident to identify and avoid triggers from the traumatic experience, encourage the resident to voice feelings of nervousness, fears, and general uneasiness related to trauma history and refer to physician as needed, observe for signs of re-traumatization such as anxiety, avoidance, depression, disassociation, intrusive thoughts, new/worsening behaviors, or sleep disturbances, provide supportive contacts to resident as needed, and offer psychiatric and supportive services to the resident and/or resident representative. The care plan indicated to add resident specific trauma triggers, however there were none added. The nurse's note, dated 12/9/22 at 10:21 a.m., indicated the resident was refusing her medications. She was educated on the importance of taking her medications as scheduled, and the adverse effects that included up to and leading to death. The resident stated she understood. The care plan, initiated on 12/12/22, indicated the resident was non-compliant with physician orders and plan of care as evidenced by rejecting medications at times. The interventions included, but were not limited to, encourage the resident to actively participate in care plan and decision making, and encourage the resident to participate in decision making by offering choices and discussion of advance directives.			

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	The nurse's note, dated 12/14/22 at 11:15 a.m., indicated the resident had refused all medications, wanted to stay in bed with the door closed and lights off. The nurse's note, dated 1/6/23 at 9:20 a.m., indicated the resident continued to be poorly motivated to participate in rehab. The nurse's note, dated 1/8/23 at 9:56 a.m., indicated staff encouraged the resident to get out of her bed and come to meals but she continued to refuse. The nurse's note, dated 1/13/23 at 9:07 a.m., indicated staff encouraged the resident to get out of her bed and come to meals but she continued to refuse. The clinical record lacked documentation of any social services follow-up related to the resident's refusal of care, medication, and meals or any referrals to counseling or psychiatric services. During an observation, on 1/19/23 at 11:39 a.m., Resident 45 was lying abed staring towards her closed window. She had a flat affect and refused to complete an interview at the time. She was very quiet and reserved. During an observation, on 1/23/23 at 1:10 p.m., Resident 45 was lying abed staring towards her closed window. She indicated she did not eat lunch today, she just didn't want to. The resident's answers were short and clipped and she did not make eye contact. During an interview on 1/23/23 at 2:12 p.m., the SSD (Social Services Director) indicated all of her notes were in the clinical record either under			

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	observations or the progress notes. She did not keep any separate notes. She met with residents, some of them every week, or as needed, and she tried to do daily rounding. She would do daily rounding as needed or weekly. She said hi to the residents weekly but did not document every single time. If the resident experienced a death she would go and chat with them, talk with them, open up an event so they could document, and see how they're doing. She would put a progress note in, and would try to do it at least once a week. If they showed signs of depression, such as exhibiting a lot of tearfulness, she would offer them therapy services and to see the psychiatric NP. Signs of depression could include irritability, the stages of grief, difficulty sleeping, eating or not eating well, isolating themselves, not coming out of their rooms, or any change in their behavior. If they exhibited these symptoms she would go in and talk with them, do an assessment, notify the NP, try to talk to them about evaluation with the therapist and psychiatric services. She did not know Resident 45 very well. She was pretty quiet. During an interview on 1/23/23 at 2:29 p.m., the SSD indicated Resident 45's spouse had died recently and she didn't want any psychiatric services when she first came in. Initially the resident was going to transition to Assisted Living, but she wasn't doing great medically and they decided to have her stay in long term care. She was very private and did not talk much at all. She was aware the resident didn't want to come out of her room. She was not aware of the resident refusing meals. She had asked the resident about psychiatric services but had not documented it. She was very resistant. She would talk to her at her quarterly review and try to get her to open up and get the services, she thought they would be good for her.			

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During an observation on 1/24/23 at 12:57 p.m., Resident 45 was laying abed, still in her pajamas. Her meal tray was untouched. She indicated she didn't feel like eating and was feeling down. Her answers were short and quiet. She remained abed, staring towards the closed window during the conversation.

During an interview on 1/25/23 at 11:54 a.m., the Director of Nursing indicated they believed the resident's behavior was just her normal and that it was just who she was.

2. The clinical record for Resident 20 was reviewed on 1/23/23 at 1:55 p.m. The diagnoses included, but were not limited to, traumatic subdural hemorrhage without loss of consciousness, metabolic encephalopathy, sepsis, unspecified organism, urinary tract infection, pneumonia, unspecified organism, acute respiratory failure with hypoxia, acute kidney failure, surgical aftercare following surgery on the digestive system, paroxysmal atrial fibrillation, depression, anxiety disorder, and insomnia.

The Admission MDS assessment, dated 11/14/22, indicated Resident 20 was moderately cognitively intact.

The care plan, dated 12/29/22, indicated the resident recently experienced the death and dying of a someone close to them. The resident was progressing through the stages of grief. The interventions included, but were not limited to, encourage the resident to continue to eat meals in the dining room with other residents, encourage the resident to participate in structured activities and individual leisure activities, life enrichment, nursing, and social services, provide supportive

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	counseling contacts as needed, refer to psychiatric services as needed, monitor for increased signs and symptoms of depression, observe the resident's mood, affect, and behaviors with all hands-on care and contacts. The clinical record lacked documentation indicating the resident was seen by the Social Services during the grieving process. The nurse's note, dated 12/29/22 at 9:16 a.m., indicated the resident recently lost his spouse. Staff would monitor the resident for any depression or adverse effects. The nurse's note, dated 12/30/22 at 2:20 a.m., indicated the resident had seemed sadder during the shift, but no tearfulness or signs and symptoms of increased depression. The nurse's note, dated 12/31/22 at 1:51 p.m., indicated the resident's family member transported the resident to his family member's funeral. He had been very quiet during the shift. During an interview on 1/24/23 at 1:10 p.m., LPN (Licensed Practical Nurse) 9 indicated when a resident lost a loved one staff would monitor for increased depression symptoms like tearfulness, sadness, lack of interest and decreased appetite. She would sit 1 on 1 with the resident and encourage the resident to express his feelings and do more frequent checks. If she identified these symptoms of increased depression she would notify the DON, psychiatric services, and make the SSD aware. The Director of Social Services Job Description, provided on 1/25/23 at 1:10 p.m. by the Campus Support Clinical, indicated the Duties and			

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	Responsibilities of the Director of Social Services included, but were not limited to, "... 4. Reviews and revises care plans and assessments as necessary... 9. Ensure that social service progress notes are informative and descriptive of the services provide and of the resident's response to the service..." 3.1-34(a)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive			

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HARRISON SPRINGS HEALTH CAMPUS	871 PACER DRIVE NW CORYDON, IN 47112

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	psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to ensure residents were free from unnecessary psychotropic medications for 1 of 5 residents reviewed for Unnecessary Psychotropic Medication Use. (Resident 15) Findings include: The clinical record for Resident 15 was reviewed on 7/13/21 at 10:38 a.m. The diagnoses included, but were not limited to, generalized anxiety disorder, major depressive disorder, repeated falls, cognitive communication deficit, unsteadiness on feet, insomnia, and dementia with behavioral disturbance. The Quarterly MDS (Minimum Data Set) assessment, dated 10/18/22, indicated the resident was severely cognitively impaired.	F 0758	1. Resident #15 had their medication regimen reviewed with the MD/ARNP for consideration regarding unnecessary medications. The identified resident did not suffer any adverse events from the alleged deficient practice. 2. All residents residing at the campus had their current medication regimen reviewed by the Pharmacist to ensure residents were free from unnecessary medications. Residents found to be in question were reviewed with the MD/ARNP with documented rationale or medications discontinued as ordered by the physician. There were no other findings.	02/10/2023

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	The physician's orders dated 4/3/22 included, but were not limited to, sertraline 50 mg (milligram) tablet once a day, memantine 5 mg tablet twice a day, buspirone 15 mg tablet twice a day, alprazolam 0.25 mg tablet at bedtime with a start date of 4/4/22, and Abilify (aripiprazole) 1 mg at bedtime with a start date of 9/5/22. The care plan, dated 12/7/22 and last revised on 1/17/23, indicated the resident was at risk for adverse consequences related to receiving antipsychotic medication for: dementia with behavior disturbance. The interventions included but were not limited to, GDR (Gradual Dose Reduction) at least twice a year unless contraindicated, observe and report signs of sedation, anticholinergic and/or extrapyramidal symptoms, administer medication per physician order, review for continued need at least quarterly, attempt to give the lowest dose possible, and pharmacy consultant review as needed. The clinical record lacked documentation indicating the resident had more than 1 behavior before adding an antipsychotic medication. The nurse's note, dated 7/8/22 at 1:11 p.m., indicated the NP (Nurse Practitioner assessed the resident on 7/7/22. The GDR, dated 6/2/22, indicated the decrease in the Abilify dose was effective. A new order was received to discontinue the Abilify. The nurse's note, dated 7/18/22 at 2:38 p.m., indicated the resident had no adverse reactions observed related to the GDR of Abilify. The resident was pleasant and cooperative with staff. She was out of her room and going to the dining room for meals.		3. The DHS and/or designee provided re-education on 2/7/2023 with licensed nurses employed at the campus regarding our policy and procedures regarding Drug regimen free from unnecessary drugs. The DHS and/or designee will perform audits of four resident records, three times per week, for six months to ensure any residents medication regiment is free from unnecessary medications. All resident records will continue to be reviewed by the pharmacist monthly to ensure any residents medication regiment is free from unnecessary medications with pharmacy recommendations completed as needed for any resident with questionable orders. DHS and/or designee will review all pharmacy recommendations for any unnecessary medication reviews daily Monday through Friday for six months to ensure any residents medication regiment is free from unnecessary medications. 4. As a quality measure, the ED or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	The nurse's note, dated 9/1/22 at 9:52 p.m., indicated the resident was yelling at the staff. She was upset with staff regarding her current isolation status and related covid exposure. She was tearful and yelling at staff with numerous complaints. She complained about meals, linens being changed on bed, and staff responsiveness. Staff attempted to offer reassurance to the resident. A family member visited and offered reassurance to the resident. The resident's behavior improved after the visit with her family member. The resident had no further yelling out, and no further tearful episodes were observed. A message was left for NP to inform her of the behavior. The nurse's note, dated 9/1/22 5:15 p.m., indicated the Director of Social Services was called to the resident's room. The resident was observed yelling and tearful. The resident stated, "the man in the kitchen told me to get out, and you all are feeding me leftovers." She was in isolation and had not left her room. The CAR (Clinically at Risk) notes, dated 10/28/22, indicated the resident had orders for Abilify, buspirone, and Xanax. No behaviors were documented on the care assistance record. The CAR notes, dated 12/22/22 at 4:04 p.m., indicated the resident had orders for Abilify, buspirone, and Xanax. She remained at the facility for long term care. The targeted behaviors were being monitored, and no behaviors are noted on the care assistance record. During an interview on 1/24/22 at 1:10 p.m., LPN (Licensed Practical Nurse) 9 indicated interventions for behaviors included, but were not limited to, distraction, 1 on 1 care, offer food or			

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	fluids, toileting, and activities. She indicated nonpharmacological interventions would be used before adding or increasing the resident's medication. The resident had not had any behaviors during her care of the resident. The resident was sweet and very kind. During an interview on 1/24/23 at 1:42 p.m., the DON indicated interventions would depend on the behavior the resident was having or the cause. IDT would meet and talk about the behaviors. They would then open an event and discuss the appropriate treatment for the resident. There was not a specific number of behaviors or how often the resident had behaviors that they went by. The interventions would include talk therapy, validating feelings, investigate the root cause of the behavior, anticipate needs, and assess for pain. The facility doctor or the Nurse Practitioner would be called. The Psychotropic Medication Usage and Gradual Dose Reduction policy, last revised 11/7/22, provided on 1/25/23 at 10:53 a.m., included, but was not limited to, "...1 Residents shall receive psychotropic medications only if designated medically necessary by the prescriber, with appropriate diagnosis or documentation to support its usage. The medical necessary will be documented in the resident's medical record and in the care planning process..." 3.1-48(a)(4)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must -			

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	§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, record review, and interview, the facility failed to ensure the kitchen, dry storage room and equipment were clean and in good repair for 3 of 3 kitchen observations. This deficient practice had the potential to affect 52 of 52 residents that received food from the kitchen. Findings included: 1. During the initial tour of the kitchen on 1/19/23 between 9:20 a.m. and 9:45 a.m., while accompanied by Cook 10, the following concerns were observed: - Ice machine - around the top where the door connected to the machine, there was a moderate build-up of lime scale which dripped down both sides and in the front. - The shelf under the steam table had black and brown food particles and dirt on it and heavy rust on the metal wires.	F 0812	1. The kitchen dry storage room and equipment were cleaned and are now in good repair. 2. All residents had the potential to be affected. The DHS/IP provided safe food handling education to the dining services team on 1/27/2023. The education included guidelines for proper food handling and hand washing techniques to ensure food is being served in a sanitary manner. Additionally, the Director of Food Services (DFS) and the dietary staff were educated on kitchen cleaning procedures and hand washing on 2/7/2023 by the Dining Support staff. All staff have been reeducated on hair restraint policy. 3. The Executive Director and/or designee will perform observation	02/10/2023

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	- The drain and cover below the preparation sink had a heavy build-up of food particles in it. - The flour and sugar bins had brown streaks down the outside with crumbs on the tops. - The grill had a heavy coating of brown and black grease in the drip pan and black build-up on the grill racks. - The floor under and behind the wheels of the steamer, convection oven, dish storage racks and condiments cart had black particles in the ground-in dirt with food particles on the floor all the way to the wall. - The condiment cart had streaks down all sides. - The dry storage floor under and in front of the shelving had pepper packets, pieces of paper, and brown food crumbs with a black dirt build-up. The snack bin in the dry storage had large yellow food crumbs in it. - Walk in freezer - the floor under the shelves and in the pathway had pieces of paper, peas, carrots, and multiple brown/black spots ranging in size from a dime to a half-dollar size. - Walk-in refrigerator - the floor under and in front of the shelving had pieces of lettuce, an apple, pieces of paper, and brown crumbs. - The floor under the steam table and the food preparation table by the stove and the food preparation counter which held the slice toaster, mixer and food processor had heavy ground-in black dirt. - The big toaster had a moderate amount of black and brown bread crumbs in it. - The floor behind and under the fryer had a heavy brown grease build-up. - Around the entire kitchen, the baseboards and three (3) inches of floor, which extended from the baseboards had a build-up of black and brown dirt and food particles. - There was a heavy amount of food particles in the drain and cover under the 2 compartment sink.		audits of three random mealtimes, three times per week for 6 months in order to ensure continued compliance with safe food handling, hairnets, and proper hand washing. The Executive Director and/or designee will perform random observation audits of the kitchen equipment to check for cleanliness three times per week, 5 pieces of equipment for 6 months. 4. As a quality measure, the ED or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	There also was a scattering of white large particles on the floor to the right of the drain. - The plate warmer machine had multiple white and yellow spots down all the sides and food particles at the base and around the edge of where the plates were put into the machine. 2. During the temperature and meal service check on 1/19/23 between 11:00 a.m. and 12:30 p.m., the following concerns were observed: - The same issues already identified at 9:20 a.m. remained. - The 2 slice toaster had multiple brown spots and smears on all sides and the top had large brown dried spots on it. - The flat top had egg and potatoes residue on it. The cook was observed to place hamburgers, hot dogs, and a ham sandwich on it for lunch. - The stove and burners had a moderate amount of brown, yellow and black dried-on debris on them. - The butter pan had a thick coating of white and yellow coating around the inside. Cook 10 at this time indicated the pan was used for frying eggs and other foods, which required butter and staff just kept filling up the pan with new liquid butter as it got low. He could not remember when it was last washed. - The floor under the ice machine and the dish machine had a heavy build-up of black dirt with black particles on the shelves. - One of three food strainers which were hanging up with the spoons had a moderate coating of food particles dried on the inner rim. - Maintenance Staff 11 and 12 were observed to enter the kitchen to fix a faucet at the handwashing sink. No hairnets were observed on their heads. When questioned, both staff members indicated they did not have a hairnet on			

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	and knew they were supposed to. A large note was observed placed on the wall as one entered the kitchen which indicated "Notice - hair restraints required beyond this point: which was underlined in yellow. - The floor under the ice machine and the dish machine had a heavy build-up of black dirt with black particles on the shelves. - The shelf just below the cutting boards had a moderate amount of brown and tan food particles on it. - An inner pan and lid to a crockpot was observed on a shelf with brown and white crumbs and residue on the lid, edges and inside. - Cook 10 at this time, was observed to pick up 2 frozen hamburger patties, 2 slices of rye bread, slices of ham and 2 slices of cheese from a bag and placed them on the flat top to cook. He then placed a handful of sauerkraut onto the bread and spread it out, picked up the ham slices and placed them onto the sandwich and pressed the sandwich down. He also took some frozen chicken fingers and tossed them in a bowl of bread crumbs and placed them into the fryer. All of these things were done with the cook's bare hands. He then placed the bowl of used bread crumbs on a shelf. He also took the food processor he had just used for hot dogs, rinsed it in the 2 compartment sink and then used it to make pureed fries all the while he had the same pair of gloves on. - The mobile steam table which went to the units had multiple orange and white splatters and streaks on the front and back with food crumbs on the base. 3. During a kitchen observation on 1/23/23 between 10:30 a.m. and 11:10 a.m., the following concerns were observed: - The same issues identified on 1/19/23 at 9:40 a.m.			

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	remained. - The 2 slice toaster had multiple brown spots and smears on all sides and the top had large brown dried spots on it. - The stove and burners had a moderate amount of brown, yellow and black dried-on debris on them. - The floor under the ice machine and the dish machine had a heavy build-up of black dirt with black particles on the shelves. - The shelf just below the cutting boards had a moderate amount of brown and tan food particles on it. - An inner pan and lid to a crockpot was observed on a shelf with brown and white crumbs and residue on the lid, edges and inside. - The mobile steam table which went to the units had multiple orange and white splatters and streaks on the front and back with food crumbs on the base. In an interview with the Director of Food Services at this time, he indicated he had just put up stock in the walk-in refrigerators and freezer, so everything was good in there. On 1/24/23 at 12:55 p.m., the Director of Food Service presented a copy of the as-completed cleaning schedules for November and December 2022 and January 2023 for the kitchen. He indicated that he had been short of staff in the kitchen for 2 years and he had been pulling a lot of over hours. The cleaning schedules were being maintained as directed and the floor that had been laid was the wrong type of floor as the floor machine tended to rip up the flooring. The drains with the food particles should not have been like that. Review of the as-completed cleaning schedules			

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	between November and December 2022 and January 2023 indicated the following tasks had been signed off as having been cleaned: - Monday AM Cook - Convection oven and 2 stove burners, flat top, and drip pan every day. - Monday PM Cook - 2 stove burners and drip pan. - Monday Dietary Aide - pull out shelves food service cart clean and sanitize both sides. - Tuesday AM Cook - Flat top and drip pan every day. - Tuesday PM Cook - Backsplash on stove and flat top - Wednesday PM Cook - Deck scrub Floor - Wednesday Dietary Aide - Condiment cart was to be cleaned and organized - Thursday AM Dietary Aide - Stainless steel, clean ice machine - Thursday PM Cook - Char-grill and drip pan - Friday AM Cook - Backsplash behind equipment and sides - Friday AM Dietary Aide - Help with backsplash behind all equipment 3.1-21(i)(3)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the investigation of Complaint IN00395706. Complaint IN00395706 - Substantiated. No deficiencies related to the allegations are cited.	R 0000	The submission of this plan of correction does not indicate an admission by Harrison Springs Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and	

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	Survey dates: January 19, 20, 23, 24, and 25, 2023 Facility number: 013702 Residential Census: 25 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on January 27, 2023.		the living environment provided to the residents of Harrison Springs Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, record review, and interview, the facility failed to ensure the kitchen, dry storage room and equipment were clean and in good repair for 3 of 3 kitchen observations. This deficient practice had the potential to affect 25 of 25 residents that received food from the kitchen Findings included: 1. During the initial tour of the kitchen on 1/19/23 between 9:20 a.m. and 9:45 a.m., while accompanied by Cook 10, the following concerns were observed: - Ice machine - around the top where the door	R 0273	1. The kitchen dry storage room and equipment were cleaned and are now in good repair. 2. All residents had the potential to be affected. The DHS/IP provided safe food handling education to the dining services team on 1/27/2023. The education included guidelines for proper food handling and hand washing techniques to ensure food is being served in a sanitary manner. Additionally, the Director of Food Services (DFS) and the dietary staff were educated on kitchen	02/10/2023

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	connected to the machine, there was a moderate build-up of lime scale which dripped down both sides and in the front. - The shelf under the steam table had black and brown food particles and dirt on it and heavy rust on the metal wires. - The drain and cover below the preparation sink had a heavy build-up of food particles in it. - The flour and sugar bins had brown streaks down the outside with crumbs on the tops. - The grill had a heavy coating of brown and black grease in the drip pan and black build-up on the grill racks. - The floor under and behind the wheels of the steamer, convection oven, dish storage racks and condiments cart had black particles in the ground-in dirt with food particles on the floor all the way to the wall. - The condiment cart had streaks down all sides. - The dry storage floor under and in front of the shelving had pepper packets, pieces of paper, and brown food crumbs with a black dirt build-up. The snack bin in the dry storage had large yellow food crumbs in it. - Walk in freezer - the floor under the shelves and in the pathway had pieces of paper, peas, carrots, and multiple brown/black spots ranging in size from a dime to a half-dollar size. - Walk-in refrigerator - the floor under and in front of the shelving had pieces of lettuce, an apple, pieces of paper, and brown crumbs. - The floor under the steam table and the food preparation table by the stove and the food preparation counter which held the slice toaster, mixer and food processor had heavy ground-in black dirt. - The big toaster had a moderate amount of black and brown bread crumbs in it. - The floor behind and under the fryer had a heavy brown grease build-up.		cleaning procedures and hand washing on 2/7/2023 by the Dining Support staff. All staff have been reeducated on hair restraint policy. 3. The Executive Director and/or designee will perform observation audits of three random mealtimes, three times per week for 6 months in order to ensure continued compliance with safe food handling, hairnets, and proper hand washing. The Executive Director and/or designee will perform random observation audits of the kitchen equipment to check for cleanliness three times per week, 5 pieces of equipment for 6 months. 4. As a quality measure, the ED or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	155852	A. BUILDING 00 B. WING	01/25/2023

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	- Around the entire kitchen, the baseboards and three (3) inches of floor, which extended from the baseboards had a build-up of black and brown dirt and food particles. - There was a heavy amount of food particles in the drain and cover under the 2 compartment sink. There also was a scattering of white large particles on the floor to the right of the drain. - The plate warmer machine had multiple white and yellow spots down all the sides and food particles at the base and around the edge of where the plates were put into the machine. 2. During the temperature and meal service check on 1/19/23 between 11:00 a.m. and 12:30 p.m., the following concerns were observed: - The same issues already identified at 9:20 a.m. remained. - The 2 slice toaster had multiple brown spots and smears on all sides and the top had large brown dried spots on it. - The flat top had egg and potatoes residue on it. The cook was observed to place hamburgers, hot dogs, and a ham sandwich on it for lunch. - The stove and burners had a moderate amount of brown, yellow and black dried-on debris on them. - The butter pan had a thick coating of white and yellow coating around the inside. Cook 10 at this time indicated the pan was used for frying eggs and other foods, which required butter and staff just kept filling up the pan with new liquid butter as it got low. He could not remember when it was last washed. - The floor under the ice machine and the dish machine had a heavy build-up of black dirt with black particles on the shelves. - One of three food strainers which were hanging up with the spoons had a moderate coating of			

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	food particles dried on the inner rim. - Maintenance Staff 11 and 12 were observed to enter the kitchen to fix a faucet at the handwashing sink. No hairnets were observed on their heads. When questioned, both staff members indicated they did not have a hairnet on and knew they were supposed to. A large note was observed placed on the wall as one entered the kitchen which indicated "Notice - hair restraints required beyond this point: which was underlined in yellow. - The floor under the ice machine and the dish machine had a heavy build-up of black dirt with black particles on the shelves. - The shelf just below the cutting boards had a moderate amount of brown and tan food particles on it. - An inner pan and lid to a crockpot was observed on a shelf with brown and white crumbs and residue on the lid, edges and inside. - Cook 10 at this time, was observed to pick up 2 frozen hamburger patties, 2 slices of rye bread, slices of ham and 2 slices of cheese from a bag and placed them on the flat top to cook. He then placed a handful of sauerkraut onto the bread and spread it out, picked up the ham slices and placed them onto the sandwich and pressed the sandwich down. He also took some frozen chicken fingers and tossed them in a bowl of bread crumbs and placed them into the fryer. All of these things were done with the cook's bare hands. He then placed the bowl of used bread crumbs on a shelf. He also took the food processor he had just used for hot dogs, rinsed it in the 2 compartment sink and then used it to make pureed fries all the while he had the same pair of gloves on. - The mobile steam table which went to the units had multiple orange and white splatters and streaks on the front and back with food crumbs on the base.			

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	3. During a kitchen observation on 1/23/23 between 10:30 a.m. and 11:10 a.m., the following concerns were observed: - The same issues identified on 1/19/23 at 9:40 a.m. remained. - The 2 slice toaster had multiple brown spots and smears on all sides and the top had large brown dried spots on it. - The stove and burners had a moderate amount of brown, yellow and black dried-on debris on them. - The floor under the ice machine and the dish machine had a heavy build-up of black dirt with black particles on the shelves. - The shelf just below the cutting boards had a moderate amount of brown and tan food particles on it. - An inner pan and lid to a crockpot was observed on a shelf with brown and white crumbs and residue on the lid, edges and inside. - The mobile steam table which went to the units had multiple orange and white splatters and streaks on the front and back with food crumbs on the base. In an interview with the Director of Food Services, on 1/23/23 at 11:10 a.m., he indicated he had just put up stock in the walk-in refrigerators and freezer, so everything was good in there. On 1/24/23 at 12:55 p.m., the Director of Food Service presented a copy of the as-completed cleaning schedules for November and December 2022 and January 2023 for the kitchen. He indicated that he had been short of staff in the kitchen for 2 years and he had been pulling a lot of over hours. The cleaning schedules were being maintained as directed and the floor that had been			

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	laid was the wrong type of floor as the floor machine tended to rip up the flooring. The drains with the food particles should not have been like that. Review of the as-completed cleaning schedules between November and December 2022 and January 2023 indicated the following tasks had been signed off as having been cleaned: - Monday AM Cook - Convection oven and 2 stove burners, flat top, and drip pan every day. - Monday PM Cook - 2 stove burners and drip pan. - Monday Dietary Aide - pull out shelves food service cart clean and sanitize both sides. - Tuesday AM Cook - Flat top and drip pan every day. - Tuesday PM Cook - Backsplash on stove and flat top - Wednesday PM Cook - Deck scrub Floor - Wednesday Dietary Aide - Condiment cart was to be cleaned and organized - Thursday AM Dietary Aide - Stainless steel, clean ice machine - Thursday PM Cook - Char-grill and drip pan - Friday AM Cook - Backsplash behind equipment and sides - Friday AM Dietary Aide - Help with backsplash behind all equipment 3.1-21(i)(3)			