STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION MIDENTIFICATION NUMBER 155657		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATI COMF	(X3) DATE SURVEY COMPLETED 07/07/2023	
NAME OF	PROVIDER OR SUPPLIE	R	150 BE	ADDRESS, CITY, STATE, ZIP COD ECHMONT DR		
HARRIS	ON HEALTHCARE	CENTER	CORY	OON, IN 47112		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTI	ION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	O BE OPRIATE	COMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
F 0000						
Bldg. 00						
	IN00412084. This Extended Survey - Complaint IN0041	the Investigation of Complaint visit resulted in a Partially Immediate Jeopardy. 2084 - Federal/State deficiency	F 0000			
	related to the alleg	ations is cited at F580.				
	Survey dates: July	7 5, 6 and 7, 2023				
	Facility number: (Provider number: AIM number: 200	155657 204440				
	Census Bed Type: SNF/NF: 71 Total: 71					
	Census Payor Typ Medicare: 5 Medicaid: 52 Other: 14 Total: 71	e:				
	This deficiency reaccordance with 4	flects State Findings cited in 10 IAC 16.2-3.1.				
	Quality review con	mpleted on July 11, 2023.				
F 0580 SS=J Bldg. 00	§483.10(g)(14) N (i) A facility must resident; consult physician; and no her authority, the when there is-	(iv)(15) s (Injury/Decline/Room, etc.) lotification of Changes. immediately inform the with the resident's otify, consistent with his or resident representative(s)				
LABORATO	RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	SIGNATURE	TITLE		(X6) DATE
Brandon J	lensen		ED			07/17/2023

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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: HXDO11 Facility ID: 010597 If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155657		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 07/07/2023							
NAME OF PROVIDER OR SUPPLIER HARRISON HEALTHCARE CENTER			150 BE	STREET ADDRESS, CITY, STATE, ZIP COD 150 BEECHMONT DR CORYDON, IN 47112					
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TAG	results in injury an requiring physicial (B) A significant of physical, mental, of that is, a deterior psychosocial statuconditions or clinic (C) A need to alter (that is, a need to form of treatment consequences, or of treatment); or (D) A decision to tresident from the §483.15(c)(1)(ii). (ii) When making If (g)(14)(i) of this seensure that all per in §483.15(c)(2) is upon request to the (iii) The facility muresident and the reany, when there is (A) A change in reasignment as spot (B) A chang	nange in the resident's or psychosocial status ation in health, mental, or is in either life-threatening cal complications); treatment significantly discontinue an existing due to adverse to commence a new form transfer or discharge the facility as specified in anotification under paragraph action, the facility must tinent information specified available and provided e physician. It also promptly notify the esident representative, if the common or roommate escified in §483.10(e)(6); or sident rights under Federal gulations as specified in of this section. Its record and periodically is (mailing and email) and the resident must disclose in its	TAG		DATE				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HXDO11 Facility ID: 010597

If continuation sheet Page 2 of 8

07/25/2023 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 07/07/2023 155657 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 150 BEECHMONT DR HARRISON HEALTHCARE CENTER 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 and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on interview and record review, the facility F 0580 07/08/2023 Preparation or execution of failed to ensure the physician was notified when a this plan of correction does not resident (Resident B) complained of bilateral constitute admission or shoulder pain and malfunctioning of his automatic agreement of provider of the implantable cardioverter defibrillator for 1 of 3 truth of the facts alleged or residents reviewed for physician notification. This conclusions set forth on the deficient practice resulted in an Immediate State of Deficiencies. The Plan Jeopardy. of Correction is prepared and executed solely because it is The Immediate Jeopardy began on 6/25/23 when required by the position of the facility staff failed to notify the physician of a Federal and State Law. resident's complaint of bilateral shoulder pain and malfunctioning of the residents' automatic The Plan of Correction is implantable cardioverter defibrillator. The resident submitted in order to respond was found unresponsive on 6/26/23 and died. The to the allegation of Executive Director (ED) and Director of Nursing noncompliance cited during were notified of the Immediate Jeopardy on 7/5/23 the complaint survey at 4:35 p.m. The Immediate Jeopardy was removed conducted on June 19, 20, and on 7/07/23, but noncompliance remained at the 21 2023. Please accept this lower scope and severity level of isolated, no plan of correction as the actual harm with potential for more than minimal provider's credible allegation harm that is not immediate jeopardy. of compliance. The facility would like to Findings include: respectfully request a desk review. The clinical record for Resident B was reviewed Brandon Jensen, LNHA on 7/5/23 at 11:11 a.m. The diagnoses included, but were not limited to, hypertension and Corrective action for the presence of automatic (implanted) cardiac residents found to have been defibrillator. The quarterly MDS (Minimum Data affected by the deficient Set) assessment, dated 5/28/23, indicated the practice: resident's cognition was intact. Resident B admitted to facility on 8-2-2022. Resident B received The care plan, dated 11/15/22, indicated the internal defibrillator (AICD) during resident had an AICD (automatic implantable acute stay 11-7-2022. On cardioverter defibrillator) related to a complete 6/25/2023 resident atrioventricular block. The interventions included, reportedbilateral shoulder pain and

PRINTED: 07/25/2023 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION DENTIFICATION NUMBER 155657 NAME OF PROVIDER OR SUPPLIER HARRISON HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIE TAG REGULATORY OR LSC IDENTIFYING INFORMATION DATE DETIFICATION BY White Consumers and the was administered 4 mg (milligrams) of Zofran (antiemetic) as ordered by the physician on 4/18/23. The progress note, dated 6/25/23 at 4:44 p.m., indicated the resident complained of bilateral shoulder pain and pacemaker complications. The resident was assessed with the following findings: EX2) MULTIPLE CONSTRUCTION A BUILDING 0 STREET ADDRESS, CITY, STATE, ZIP COD 150 BEECHMONT DR CORYDON, IN 47112 ID PROVIDERS PLAN OF CORRECTION EXCEL PROFINE DEFICIENCY COMPLETION DATE ID PROVIDERS PLAN OF CORRECTION EXAMINATION DATE ID PROVIDERS PLAN OF CORRECTION CONSTRUCTION (X5) COMPLETION DATE OCOMPLETION COMPLETION COMPLETION DATE OCOMPLETION COMPLETION DATE OCOMPLETION COMPLETION COMPLETION DATE OCOMPLETED COMPLETED COMPLETED COMPLETED COMPLETION COMPLETION DATE OCOMPLETION COMPLETION COMPLETION DATE OCOMPLETION COMPLETION COMPLETION DATE OCOMPLETION COMPLETION DATE OCOMPLETION COMPLETION DATE OCOMPLETION COMPLETION CASH COMPLETION COMPLETION CASH CASH CASH CASH CASH CASH CASH CASH	CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
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The progress note, dated 6/25/23 at 4:44 p.m., indicated the resident complained of bilateral shoulder pain and pacemaker complications. The resident was assessed with the following findings: facility have the potential to be affected by the alleged deficient practice. DON/Designee have reviewed all residents with change of condition		4/18/23.				<u> </u>	_	
The progress note, dated 6/25/23 at 4:44 p.m., indicated the resident complained of bilateral shoulder pain and pacemaker complications. The resident was assessed with the following findings: affected by the alleged deficient practice. DON/Designee have reviewed all residents with change of condition								
indicated the resident complained of bilateral shoulder pain and pacemaker complications. The resident was assessed with the following findings: practice. DON/Designee have reviewed all residents with change of condition						1		
shoulder pain and pacemaker complications. The resident was assessed with the following findings: DON/Designee have reviewed all residents with change of condition			-				ent	
resident was assessed with the following findings: residents with change of condition			-			1 -		
			-			_		
						1		
apical heart rate of 67 after one minute of for the last 14 days to ensure		1 ^				-		
auscultation, temperature was 97.8, respirations physician notification, family		1	-			1		
were 18, and blood pressure was 151/81. The notification, and follow-up was			-			·		
resident was educated that he would be completed as appropriate. Upon						1		
discharged tomorrow. The resident asked to be completion of the audit, no other		1						
sent to the hospital. Upon education that he was residents were identified as being							٠ ١	
to be discharged tomorrow, the resident decided affected by the alleged deficient						affected by the alleged deficie	ent	
to contact his spouse prior to his decision to be practice.		to contact his spous	e prior to his decision to be			practice.		
sent to the hospital. DON/Designee reviewed all		sent to the hospital.				DON/Designee reviewed all		
residents with AICD and						residents with AICD and		
The progress note, dated 6/26/23 at 1:21 p.m., implemented daily monitoring		The progress note, or	dated 6/26/23 at 1:21 p.m.,			implemented daily monitoring	j	
indicated the resident complained of nausea at orders for completion by licensed		indicated the resider	nt complained of nausea at			orders for completion by licen	nsed	
times and his as needed Zofran was administered nurses to ensure compliance with		-				nurses to ensure compliance	with	
as prescribed. daily monitoring of residents with		as prescribed.				daily monitoring of residents v	with	
AICDs to include: No symptoms of						AICDs to include: No sympton	ms of	
Review of the June 2023 medication administration malfunction/failure, slowed or		Review of the June	2023 medication administration			1		
record (MAR) indicated the resident received irregular heartbeat, pain with		record (MAR) indic	cated the resident received					
Zofran 4 mg at 8:34 a.m. and 5:49 p.m. for nausea potential to relate to cardiac						1		
and meclizine (medication for dizziness) 12.5 mg at concern, shortness of breath,		_	-			1 · · ·	,	
8:34 a.m., per standing order, on 6/26/23. Between faintness/dizziness, unexplained		,	,					
6/1/23 and 6/26/23, the resident's MAR indicated falls, unexplained weakness.		_	_			·		

6/1/23 and 6/26/23, the resident's MAR indicated 6/26/23 was the first time the resident had

An audit was conducted for all

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION			ľ í	A. BUILDING 00		COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		-				
		155657	B. W	B. WING 07/07/2023				
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
WANTE OF TROVIDER OR SOLITEIER					ECHMONT DR			
HARRIS	ON HEALTHCARE	CENTER		CORYE	OON, IN 47112			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	FICIENCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		.TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	_	of the Zofran and the first time			resident appointments for last	30		
	the resident had req	quested the meclizine.			days from June 27, 2023 to			
					present to ensure all appointments			
		dated 6/26/23 at 9:30 p.m.,			were completed as ordered ar	ere completed as ordered and if		
		ent was found unresponsive			resident refusal of appointmer			
	1	ere were no respirations and			including missed AICD follow	w up		
		diopulmonary Resuscitation)			appointments, occurred that			
	_	vas initiated and 911 called. CPR			resident was educated on risk			
		1 9:09 p.m. when EMT's			potential adverse outcomes a			
		al technicians) arrived. The			physician was notified of refus			
	l -	nable to resuscitate the resident			Measures/systemic changes	put		
	and time of death was called at 9:29 p.m.				into place to ensure the			
					deficient practice does not			
	The clinical record lacked documentation of the				recur:			
	physician's notification related to Resident B's				DON/Designee have educated	d all		
	bilateral shoulder pain and complaints of the				licensed nurses on the facility	's		
	malfunctioning AICD or any resident education				policy for notification of COC t	io		
	on refusing to go for his AICD check.				MD/NP and family, internal			
					devices / pacemaker and follo	w up		
	_	v on 7/5/23 at 11:43 a.m., LPN			appointments to include refus	al of		
	`	Nurse) 3 indicated he did not			appointments, and cardiac sig	ıns		
		n of the resident's complaints			and symptoms.			
	of shoulder pain an	-			DON/Designee completed			
	1	was unaware he had to do so			education with all licensed nur			
	_	e physician was to be notified			on potential negative outcome	es of		
	when the resident was sent out. The resident I not made that decision at that point. It was				missed AICD follow up			
					appointments to include devic	е		
		his shift, and he passed the			failure, cardiac arrest, and			
		LPN 4 during shift change. At			potential death.			
	_	clarified malfunctions as the			DON/Designee completed			
	_	him that his heartbeat felt			education with all licensed nur			
	irregular and his Al	ICD was malfunctioning.			regarding completion of reside	ent		
		-/-/			education and notification to			
		v on 7/5/23 at 11:57 a.m., LPN 4			physician related to missed or	•		
		ot told anything about the			refused AICD follow up			
		ng of bilateral shoulder pain or			appointments.			
	1	CD. The only thing she was			The physician will be notified l	•		
		sident was going to be			licensed nurse of any resident			
	_	day and the resident had been			an implanted device who miss	ses		
	coming up with all kinds of excuses not to go				an appointment or refuses 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 <u>00</u>		COMPLETED		
		155657	B. WING 07/07/202			/2023	
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					ECHMONT DR		
HARRIS	ON HEALTHCARE	CENTER			DON, IN 47112		
			1		, T		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	'S PLAN OF CORRECTION TIVE ACTION SHOULD BE	
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			DATE
	home. LPN 3 told her he had checked everything,				appointment.		
		s fine. LPN 4 passed			Any resident who misses an		
		esident between 7:00 p.m. and			appointment or refuses an		
	_	3. There was no documented			appointment will receive education by licensed staff regarding risks associated with missed follow-up		
	_	related to the resident's prior					
		eral shoulder pain or complaints					
	of AICD malfunction	ons during LPN 4's shift.			of implanted devices to includ	е	
	0. 5/5/00 . 0.40	d P d P			risk of device failure, cardiac		
	_	.m., the Executive Director			arrest, and potential death.		
	1 ~	andated copy of the document			DON/Designee will monitor the	е	
		of Change in Condition". It			order listing report and		
		ot limited to, "PolicyIt is the			appointment schedule daily fo	r	
	policy of this facility to provide resident centered				appointment follow-ups for		
		needsconcerns of the			residents with implanted device		
	residents. The safety of residentsis of primary				daily ongoing to ensure physic		
	_	Centers for Medicaid and			notification of missed or refuse		
		(CMS) requires that processes			appointment and resident/fam	-	
		ications of acute changes such			are educated on risk of potent		
		ter must inform the resident,			adverse outcomes to include i		
		ident's physicianwhen there			of device failure, cardiac arres	st, or	
	is a change requirin				potential death.		
		e in the residents physical			DON/Designee educated all		
		ng but not limited to			licensed nurses on the daily		
	life-threatening co				monitoring of signs and sympt		
	1 -	tificationsThe attending			of potential problems with AIC	D to	
	1	ptly notified of significant			include symptoms of		
	1	n, and the medical record must			malfunction/failure, slowed or		
		on, response, and			irregular heartbeat, pain with		
	·	mented to address the			potential to relate to cardiac		
	resident's condition	"			concern, shortness of breath,		
					faintness/dizziness, unexplain	ed	
		pardy, that began on 6/25/23,			falls, unexplained weakness.		
		07/23, when the facility			Licensed staff will monitor		
		wing: The DON/Designee			residents with AICD daily for		
		nts with a change of condition			signs/symptoms of AICD failu		
	for the last 14 days				DON/Designee will review 24-		
		notification, and follow-up was			report to identify resident char	nge	
		priate. The DON/Designee			in conditions at each clinical		
	reviewed all resider	nts with an AICD and			morning meeting to ensure all		
	implemented daily monitoring orders for				changes in condition are repo	rted	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155657		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/07/2023			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 150 BEECHMONT DR CORYDON, IN 47112				
	SUMMARY: (EACH DEFICIEN REGULATORY OR completion by licen compliance with da symptoms of malfu irregular heartbeat, to cardiac concern, faintness/dizziness, unexplained weakn for all resident appoin ordered and if resid including AICD fol education would be potential adverse ou notified of refusals. educated on the face COC to MD/NP and devices/pacemaker include refusal of aj and symptoms, pot missed AICD follow device failure, cardi completion of resid to physician related follow-up appointm	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION sed nurses to ensure illy monitoring to include no netion/failure, slowed or pain with potential to related shortness of breath, unexplained falls, and ess. An audit was conducted bintments for the last 30 days tments were completed as ent refused appointment, low-up appointments, provided on the risk for atcomes and physician All licensed nurses were fility's policy for notification of all family, internal and follow-up appointments to oppointments and cardiac signs ential negative outcomes of w-up appointments to include ac arrest, and potential death, ent education and notification to missed or refused AICD tents, and on the daily and symptoms of potential	150 BE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY) to physician as appropriate for follow-up including daily review AICD failure signs and symptomonitoring. Corrective actions to be monitored to ensure the deficient practice will not recur: DON/Designee will audit 5 residents daily for change in conditions x 4 weeks and 10 residents weekly for change in condition x 4 weeks then, 5 resident's weekly x 4 weeks to ensure that any change in condition is reported to physic as appropriate. DON/Designee will observe nursing assessments complete by 5 nurses weekly x 4 weeks, then a nurses weekly x 4 weeks, then nurse weekly x 4 weeks, and monthly thereafter completed residents with implanted device DON/Designee will monitor	DATE W of oms ian ed a 1 on ees.		
	This Federal tag rel 3.1-5(a)(2)	ates to Complaint IN00412084		follow-up appointment complia and physician notification for residents with implanted device daily on an ongoing basis. DON/Designee will monitor compliance with resident education regarding risk associated with missing follow appointments related to implait devices daily on an ongoing be DON/Designee will monitor assessments of AICD failure sand symptoms and physician notification daily on an ongoing	r-up nted asis.		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/25/2023 FORM APPROVED OMB NO. 0938-039

CENTERSTON	WIEDICHNE & WEDIC	IID SERVICES			0.11	D 110. 0700 007	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPL		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
155657			B. WING 07/07/2023				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 150 BEECHMONT DR CORYDON, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG			DATE	
				basis. The DON/Unit Manager/Desig will present the results of thes audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Finitiated. The QAPI committee determine when 100% complisis achieved or if ongoing monitoring is required.	ee Plan e will		

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