STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	07/07/2023

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00412084. This visit resulted in a Partially Extended Survey - Immediate Jeopardy. Complaint IN00412084 - Federal/State deficiency related to the allegations is cited at F580. Survey dates: July 5, 6 and 7, 2023 Facility number: 010597 Provider number: 155657 AIM number: 200204440 Census Bed Type: SNF/NF: 71 Total: 71 Census Payor Type: Medicare: 5 Medicaid: 52 Other: 14 Total: 71 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 11, 2023.	F 0000		
F 0580 SS=J Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which			

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

Brandon Jensen | ED | 07/17/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part,			

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	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 failed to ensure the physician was notified when a resident (Resident B) complained of bilateral shoulder pain and malfunctioning of his automatic implantable cardioverter defibrillator for 1 of 3 residents reviewed for physician notification. This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 6/25/23 when the facility staff failed to notify the physician of a resident's complaint of bilateral shoulder pain and malfunctioning of the residents' automatic implantable cardioverter defibrillator. The resident was found unresponsive on 6/26/23 and died. The Executive Director (ED) and Director of Nursing were notified of the Immediate Jeopardy on 7/5/23 at 4:35 p.m. The Immediate Jeopardy was removed on 7/07/23, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: The clinical record for Resident B was reviewed on 7/5/23 at 11:11 a.m. The diagnoses included, but were not limited to, hypertension and presence of automatic (implanted) cardiac defibrillator. The quarterly MDS (Minimum Data Set) assessment, dated 5/28/23, indicated the resident's cognition was intact. The care plan, dated 11/15/22, indicated the resident had an AICD (automatic implantable cardioverter defibrillator) related to a complete atrioventricular block. The interventions included,	F 0580	**Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law.** **The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the complaint survey conducted on June 19, 20, and 21 2023. Please accept this plan of correction as the provider's credible allegation of compliance.** **The facility would like to respectfully request a desk review.** **Brandon Jensen, LNHA** **Corrective action for the residents found to have been affected by the deficient practice:** Resident B admitted to facility on 8-2-2022. Resident B received internal defibrillator (AICD) during acute stay 11-7-2022. On 6/25/2023 resident reportedbilateral shoulder pain and	07/08/2023

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	but were not limited to, defibrillator checks as ordered and follow up with cardiology as ordered. The progress note, dated 6/13/23 at 1:28 p.m., indicated the resident refused to go to his appointment for his AICD check due to complaints of not feeling well. The resident requested his oxygenation be checked and complained of nausea. The resident's oxygenation was 90% on 2 liters of oxygen and he 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: apical heart rate of 67 after one minute of auscultation, temperature was 97.8, respirations were 18, and blood pressure was 151/81. The resident was educated that he would be discharged tomorrow. The resident asked to be sent to the hospital. Upon education that he was to be discharged tomorrow, the resident decided to contact his spouse prior to his decision to be sent to the hospital. The progress note, dated 6/26/23 at 1:21 p.m., indicated the resident complained of nausea at times and his as needed Zofran was administered as prescribed. Review of the June 2023 medication administration record (MAR) indicated the resident received Zofran 4 mg at 8:34 a.m. and 5:49 p.m. for nausea and meclizine (medication for dizziness) 12.5 mg at 8:34 a.m., per standing order, on 6/26/23. Between 6/1/23 and 6/26/23, the resident's MAR indicated 6/26/23 was the first time the resident had		concern Resident B was assessed by nurse with no noted change from baseline with vital signs within normal limits. The facility was unable to validate that physician had been notified of resident reported bilateral shoulder pain and AICD complications. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who reside in the facility have the potential to be affected by the alleged deficient practice. DON/Designee have reviewed all residents with change of condition for the last 14 days to ensure physician notification, family notification, and follow-up was completed as appropriate. Upon completion of the audit, no other residents were identified as being affected by the alleged deficient practice. DON/Designee reviewed all residents with AICD and implemented daily monitoring orders for completion by licensed nurses to ensure compliance with daily monitoring of residents with AICDs to include: No symptoms of malfunction/failure, slowed or irregular heartbeat, pain with potential to relate to cardiac concern, shortness of breath, faintness/dizziness, unexplained falls, unexplained weakness. An audit was conducted for all	

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	requested 2 doses of the Zofran and the first time the resident had requested the meclizine. The progress note, dated 6/26/23 at 9:30 p.m., indicated the resident was found unresponsive lying in his bed. There were no respirations and no pulse. CPR (Cardiopulmonary Resuscitation) and defibrillating was initiated and 911 called. CPR was continued until 9:09 p.m. when EMT's (emergency medical technicians) arrived. The paramedics were unable to resuscitate the resident and time of death was called at 9:29 p.m. The clinical record lacked documentation of the physician's notification related to Resident B's bilateral shoulder pain and complaints of the malfunctioning AICD or any resident education on refusing to go for his AICD check. During an interview on 7/5/23 at 11:43 a.m., LPN (Licensed Practical Nurse) 3 indicated he did not notify the physician of the resident's complaints of shoulder pain and possible AICD malfunctioning. He was unaware he had to do so and thought that the physician was to be notified when the resident was sent out. The resident had not made that decision at that point. It was towards the end of his shift, and he passed the information on the LPN 4 during shift change. At 12:55 p.m., LPN 3 clarified malfunctions as the resident reported to him that his heartbeat felt irregular and his AICD was malfunctioning. During an interview on 7/5/23 at 11:57 a.m., LPN 4 indicated she was not told anything about the resident complaining of bilateral shoulder pain or malfunctioning AICD. The only thing she was told was that the resident was going to be discharged on Monday and the resident had been coming up with all kinds of excuses not to go		resident appointments for last 30 days from June 27, 2023 to present to ensure all appointments were completed as ordered and if resident refusal of appointment, including missed AICD follow up appointments, occurred that resident was educated on risk for potential adverse outcomes and physician was notified of refusals. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** DON/Designee have educated all licensed nurses on the facility's policy for notification of COC to MD/NP and family, internal devices / pacemaker and follow up appointments to include refusal of appointments, and cardiac signs and symptoms. DON/Designee completed education with all licensed nurses on potential negative outcomes of missed AICD follow up appointments to include device failure, cardiac arrest, and potential death. DON/Designee completed education with all licensed nurses regarding completion of resident education and notification to physician related to missed or refused AICD follow up appointments. The physician will be notified by a licensed nurse of any resident with an implanted device who misses an appointment or refuses an	

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	home. LPN 3 told her he had checked everything, and the resident was fine. LPN 4 passed medication to the resident between 7:00 p.m. and 7:30 p.m. on 6/25/23. There was no documented nursing assessment related to the resident's prior complaints of bilateral shoulder pain or complaints of AICD malfunctions during LPN 4's shift. On 7/5/23 at 2:43 p.m., the Executive Director provided a current undated copy of the document titled "Notification of Change in Condition". It included, but was not limited to, "Policy ...It is the policy of this facility to provide resident centered care that meets the ...needs ...concerns of the residents. The safety of residents ...is of primary importance ...The Centers for Medicaid and Medicare Services (CMS) requires that processes be in place for notifications of acute changes such as cardio ...The center must inform the resident, consult with the resident's physician ...when there is a change requiring such notification ...Significant change in the residents physical condition ...including but not limited to ...life-threatening condition ...clinical complications ...Notifications ...The attending practitioner is promptly notified of significant changes in condition, and the medical record must reflect the notification, response, and interventions implemented to address the resident's condition ...." The Immediate Jeopardy, that began on 6/25/23, was removed on 7/07/23, when the facility conducted the following: The DON/Designee reviewed all residents with a change of condition for the last 14 days to ensure physician notification, family notification, and follow-up was completed as appropriate. The DON/Designee reviewed all residents with an AICD and implemented daily monitoring orders for		appointment. Any resident who misses an appointment or refuses an appointment will receive education by licensed staff regarding risks associated with missed follow-up of implanted devices to include risk of device failure, cardiac arrest, and potential death. DON/Designee will monitor the order listing report and appointment schedule daily for appointment follow-ups for residents with implanted devices daily ongoing to ensure physician notification of missed or refused appointment and resident/family are educated on risk of potential adverse outcomes to include risk of device failure, cardiac arrest, or potential death. DON/Designee educated all licensed nurses on the daily monitoring of signs and symptoms of potential problems with AICD to include symptoms of malfunction/failure, slowed or irregular heartbeat, pain with potential to relate to cardiac concern, shortness of breath, faintness/dizziness, unexplained falls, unexplained weakness. Licensed staff will monitor residents with AICD daily for signs/symptoms of AICD failure. DON/Designee will review 24-hour report to identify resident change in conditions at each clinical morning meeting to ensure all changes in condition are reported	

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	completion by licensed nurses to ensure compliance with daily monitoring to include no symptoms of malfunction/failure, slowed or irregular heartbeat, pain with potential to related to cardiac concern, shortness of breath, faintness/dizziness, unexplained falls, and unexplained weakness. An audit was conducted for all resident appointments for the last 30 days to ensure all appointments were completed as ordered and if resident refused appointment, including AICD follow-up appointments, education would be provided on the risk for potential adverse outcomes and physician notified of refusals. All licensed nurses were educated on the facility's policy for notification of COC to MD/NP and family, internal devices/pacemaker and follow-up appointments to include refusal of appointments and cardiac signs and symptoms, potential negative outcomes of missed AICD follow-up appointments to include device failure, cardiac arrest, and potential death, completion of resident education and notification to physician related to missed or refused AICD follow-up appointments, and on the daily monitoring of signs and symptoms of potential problems with AICD. This Federal tag relates to Complaint IN00412084 3.1-5(a)(2)		to physician as appropriate for follow-up including daily review of AICD failure signs and symptoms monitoring. **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 physician as appropriate. DON/Designee will observe nursing assessments completed by 5 nurses weekly for competency x 4 weeks, then 3 nurses weekly x 4 weeks, then 1 nurse weekly x 4 weeks, and monthly thereafter completed on residents with implanted devices. DON/Designee will monitor follow-up appointment compliance and physician notification for residents with implanted devices daily on an ongoing basis. DON/Designee will monitor compliance with resident education regarding risk associated with missing follow-up appointments related to implanted devices daily on an ongoing basis. DON/Designee will monitor assessments of AICD failure signs and symptoms and physician notification daily on an ongoing	

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			basis. The DON/Unit Manager/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	