|                                    | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155657  |  | A. BU | X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP COD  X3) DATE SURVEY COMPLETED 06/10/2024 |   |                           | ETED                       |
|------------------------------------|---|--|-------|---|---|---------------------------|----------------------------|
|                                    | PROVIDER OR SUPPLIE   |  |       | 150 BEECHMONT DR<br>CORYDON, IN 47112   |   |                           |                            |
| (X4) ID<br>PREFIX<br>TAG<br>F 0000 | (EACH DEFICIE   | T STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION |       | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)   | ATE                       | (X5)<br>COMPLETION<br>DATE |
| Bldg. 00                           | IN00434995.  Complaint IN0043 related to the alleg and F921.  Survey dates: Junification Junification Facility number: Of Provider number: AIM number: 200 Census Bed Type: SNF/NF: 83  Total: 83  Census Payor Typ Medicare: 4  Medicaid: 45  Other: 34  Total: 83  These deficiencies accordance with 4 | 155657 1204440 e: reflect State Findings cited in                                      | F 00  | 000   | Preparation or execution of this plan of correction does constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the State of Deficiencies. The Pl of Correction is prepared an executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to resport to the allegation of noncompliance cited during the survey conducted June 2024. Please accept this pla of correction as the provider credible allegation of compliance. The facility would like to respectfully request a desk review.  Brandon Jensen, LNHA | an<br>d<br>s<br>nd<br>10, |                            |
| F 0684<br>SS=E<br>Bldg. 00         | applies to all trea<br>facility residents.<br>comprehensive a<br>facility must ensu   | a fundamental principle that tment and care provided to                                |       |   |   |                           |                            |

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

TITLE

(X6) DATE

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

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| CENTERS FOR MEDICARE & MEDICAID SERVICES |  |  |         |                      | ON   | MB NO. 0938-039                       |            |
|--|--|--|---------|----------------------|--|---------------------------------------|------------|
|  | NT OF DEFICIENCIES OF CORRECTION   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER  |         | JLTIPLE CO<br>ILDING | onstruction<br><u>00</u>   | (X3) DATE SURVEY  COMPLETED           |            |
|  |  | 155657   | B. WING |                      |  | 06/10                                 | )/2024     |
|  | PROVIDER OR SUPPLIEI   |  | •       | 150 BE               | ADDRESS, CITY, STATE, ZIP COD<br>EECHMONT DR<br>DON, IN 47112  | •                                     |            |
| (X4) ID                                  | SUMMARY  | STATEMENT OF DEFICIENCIE   |         | ID                   |  |                                       | (X5)       |
| PREFIX                                   |  | ICY MUST BE PRECEDED BY FULL   |         | PREFIX               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPE   | E                                     | COMPLETION |
| TAG                                      | `  | R LSC IDENTIFYING INFORMATION  |         | TAG                  | CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY)   | RIATE                                 | DATE       |
|  | comprehensive po<br>and the residents'<br>Based on interview<br>failed to ensure mo<br>resident (Resident I<br>ensure the nursing  | dards of practice, the erson-centered care plan, choices.  and record review, the facility nitoring was in place for a B) with a chole drain and to staff followed medication nt B, C, D and E) for 4 of 5 | F 06    | 584                  | Preparation or execution of the plan of correction does not constitute admission or agree of provider of the truth of the alleged or conclusions set for   | ement<br>facts                        | 07/09/2024 |
|  | residents reviewed Findings include:   |  |         |                      |  | ecuted solely because it is           |            |
|  | 1.a. The clinical record for Resident B was reviewed on 6/8/24 at 12:13 p.m. The resident's diagnoses included, but were not limited to, cholecystitis and hypertension.  The hospital discharge summary, dated 5/17/24 at 10:36 a.m., indicated the resident had acute cholecystitis with sepsis and discharged with a percutaneous chole tube (drain).  The admission assessment, dated 5/17/24 at 2:07 p.m., indicated the resident was admitted with a chole drain to the right side.  The progress note, dated 5/17/24 at 1:51 p.m., indicated the resident had a chole drain to the right side of the abdomen with no signs or symptoms of infection observed. |  |         |                      | and State Law. The Plan of Correction is submitted in order to respon the allegation of noncomplia cited during the survey cond  | d to<br>nce                           |            |
|  |  |  |         |                      | June 10, 2024. Please acce<br>this plan of correction as the<br>provider's credible allegation<br>compliance.<br>The facility would like to<br>respectfully request a desk r<br>Brandon Jensen, LNHA   | of                                    |            |
|  |  |  |         |                      | STEP 1 Corrective action for residents found to have been affected by the deficient practice. Residents B, C, D and E we harmed by the alleged defici practice. Residents B,C, D, and E, D, and E, D, C, D, and E, D, C, D, S, C, D, | n<br>ctice:<br>re not<br>ent<br>and E |            |
|  | p.m., indicated the with a chole drain i was only a short su The drain was either fell out.  | ner note, dated 5/20/24 at 12:50 resident supposedly admitted n the right side, however, there ture hanging from her bed. er accidentally pulled our or it   |         |                      | were part of a confidential su<br>and therefore not identified.  STEP 2 Corrective action tal<br>those residents having the<br>potential to be affected by the<br>same deficient practice:   | ken for<br>e                          |            |
|  | The clinical record  | lacked documentation of any  |         |                      | All residents who have order   | s with                                |            |

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monitoring of the resident's chole drain between

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blood pressure parameters or a

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| EPARTMENT OF HEALTH AND HUMAN SERVICES   |                            |                            |      |  |  |  |  |  |  |  |
|--|----------------------------|----------------------------|------|--|--|--|--|--|--|--|
| CENTERS FOR MEDICARE & MEDICAID SERVICES |                            |                            |      |  |  |  |  |  |  |  |
| STATEMENT OF DEFICIENCIES                | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | (X3) |  |  |  |  |  |  |  |
| AND PLAN OF CORRECTION                   | IDENTIFICATION NUMBER      | A. BUILDING 00             |      |  |  |  |  |  |  |  |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155657 |  | ` ′  | UILDING<br>ING | ONSTRUCTION  00          | _ СОМР<br>06/10   | (X3) DATE SURVEY COMPLETED 06/10/2024 |                 |
|--|--|--|----------------|--------------------------|---|---------------------------------------|-----------------|
|  | PROVIDER OR SUPPLIE                                |  |                | 150 BE                   | ADDRESS, CITY, STATE, ZIP CO<br>ECHMONT DR<br>DON, IN 47112 | D                                     |                 |
| (X4) ID  |  | STATEMENT OF DEFICIENCIE                                   |                | ID                       | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHO     | ECTION                                | (X5)            |
| PREFIX<br>TAG  | `  | NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION |                | PREFIX<br>TAG            | CROSS-REFERENCED TO THE AP                                  | PROPRIATE                             | COMPLETION DATE |
| IAG  |  | n. and 5/20/24 at 12:50 p.m. when                          |                | IAG                      | chole drain could be affe                                   | acted by                              | DATE            |
|  | _  | t in place by the nurse                                    |                |                          | the alleged deficient pra                                   | •                                     |                 |
| practitioner.  |  |  |                | 30-day lookback of all m |   |                                       |                 |
|  |  |  |                | with blood pressure para |   |                                       |                 |
|  | During an interview                                | w on 6/10/24 at 10:47 a.m., the                            |                |                          | was completed to ensur                                      |                                       |                 |
|  |  | g indicated the staff should                               |                |                          | medications had been  |                                       |                 |
|  |  | ing the resident's drain.                                  |                |                          | administered according                                      | to                                    |                 |
|  |  |  |                |                          | physicians' orders. A 30                                    |                                       |                 |
|  | 1.b. The physician'                                | s order, dated 5/18/24,                                    |                |                          | lookback of all admissio                                    | •                                     |                 |
|  | indicated Resident                                 | B was to receive Metoprolol                                |                |                          | completed to ensure pro                                     | per                                   |                 |
|  | Succinate ER (exte                                 | ended release), 100 mg                                     |                |                          | monitoring was in place                                     | for any                               |                 |
|  |  | for arrhythmia. Staff were to hold                         |                |                          | residents with chole dra                                    | ins. Any                              |                 |
|  |  | cation if the resident's systolic                          |                |                          | concerns were immedia                                       | tely                                  |                 |
|  | blood pressure was less than 110 or the resident's |  |                |                          | addressed.  |                                       |                 |
|  | pulse was less than                                | 1 60.  |                |                          |   |                                       |                 |
|  |  |  |                |                          | STEP 3 Measures/syste                                       |                                       |                 |
|  |  | 2024 medication administration                             |                |                          | changes put into place t                                    |                                       |                 |
|  |  | e resident's systolic blood                                |                |                          | the deficient practice do                                   | es not                                |                 |
|  | -  | nd the medication was                                      |                |                          | recur:  |                                       |                 |
|  | administered.                                      |  |                |                          | The DON/Designee held                                       |                                       |                 |
|  |  | 6/0/04   |                |                          | in-service for all nurses                                   | •                                     |                 |
|  |  | w on 6/9/24 at 11:30 a.m., RN                              |                |                          | education and expectati                                     |                                       |                 |
|  |  | 5 indicated if a resident's blood                          |                |                          | relates to the "medicatio                                   |                                       |                 |
|  | _  | rithin the parameters listed, the                          |                |                          | administration" policy ar                                   |                                       |                 |
|  |  | be held and blood pressure prior to the administration of  |                |                          | procedures including ad                                     | _                                     |                 |
|  | the medication.                                    | prior to the administration of                             |                |                          | blood pressure medicati<br>parameters according to          |                                       |                 |
|  | the medication.                                    |  |                |                          | orders. The DON/Design                                      |                                       |                 |
|  | 2 The clinical reco                                | ord for Resident C was reviewed                            |                |                          | an in-service for all nurs                                  |                                       |                 |
|  |  | .m. The resident's diagnosis                               |                |                          | provide education and                                       | 00 10                                 |                 |
|  |  | not limited to, orthostatic                                |                |                          | expectations as it relate                                   | s to the                              |                 |
|  | hypotension.                                       |  |                |                          | monitoring of chole drain                                   |                                       |                 |
|  | The physician's ord                                | der, dated 5/30/24, indicated the                          |                |                          | STEP 4 Corrective action                                    | ns to be                              |                 |
|  |  | eive Midodrine HCl   |                |                          | monitored to ensure the                                     |                                       |                 |
|  |  | mg three times a day at 8:00                               |                |                          | practice will not recur:                                    |                                       | 1               |
|  |  | nd 4:00 p.m. for hypotension (low                          |                |                          | The DON/Designee will                                       | audit 5                               |                 |
|  | _  | he resident's medication was to                            |                |                          | residents a week x 4 we                                     |                                       |                 |
|  | * '  | ent's systolic blood pressure                              |                |                          | 3 residents for week x 4                                    |                                       |                 |
|  | was greater than 12                                | -  |                |                          | then 1 resident a week                                      |                                       |                 |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |  | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY |      |          | SURVEY  |                |            |
|--|--|---|------|----------|---|----------------|------------|
| AND PLAN   | OF CORRECTION  | IDENTIFICATION NUMBER                       | A. B | UILDING  | 00  | COMPL          | ETED       |
|  |  | 155657                                      | B. W | ING      | _   | 06/10/         | /2024      |
| NAME OF T  | ADOLUDED OF CURRY TO   |   | _    | STREET A | ADDRESS, CITY, STATE, ZIP COD   |                |            |
| NAME OF P  | PROVIDER OR SUPPLIER   | i.  |      | 150 BE   | ECHMONT DR  |                |            |
| HARRISO  | ON HEALTHCARE  | CENTER                                      |      | CORYE    | OON, IN 47112   |                |            |
| (X4) ID  |  | STATEMENT OF DEFICIENCIE                    |      | ID       | PROVIDER'S PLAN OF CORRECTION   |                | (X5)       |
| PREFIX   | `  | CY MUST BE PRECEDED BY FULL                 |      | PREFIX   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE             | COMPLETION |
| TAG  | REGULATORY OR  | R LSC IDENTIFYING INFORMATION               | +    | TAG      |   |                | DATE       |
|  | Davious of the June  | 2024 mediantian administration              |      |          | for no less than 3 months and   |                |            |
|  | Review of the June 2024 medication administration record indicated the medication was administered |   |      |          | compliance is maintained to ensure blood pressure medica  | ation          |            |
|  | on the following da  |   |      |          | with parameters are administe   |                |            |
|  | on the following da  | tes and times.                              |      |          | per physician order. The  | i eu           |            |
|  | On 6/4/24 at 8:00 a.   | .m., the resident's systolic                |      |          | DON/Designee will audit all ne  | <del>-</del> W |            |
|  | blood pressure was   |   |      |          | admissions for no less than 3   |                |            |
|  | -  | p.m., the resident's systolic               |      |          | months and compliance is  |                |            |
|  | blood pressure was   |   |      |          | maintained to ensure monitori   | ng is          |            |
|  | -  | .m., the resident's systolic                |      |          | in place for any resident admit   | -              |            |
|  | blood pressure was   |   |      |          | with a chole drain.   | -              |            |
|  | On 6/5/24 at 12:00   | p.m., the resident's systolic               |      |          |   |                |            |
|  | blood pressure was 122.  |   |      |          | The DON/Designee will prese   | nt             |            |
|  |  | .m., the resident's systolic blood          |      |          | the results of these audits mor   | nthly          |            |
|  | pressure was 141.  |   |      |          | to the QAPI committee for no  |                |            |
|  |  |   |      |          | than 3 months. Any patterns t   |                |            |
|  |  | rd for Resident D was reviewed              |      |          | are identified will have an Acti  | on             |            |
|  | _  | m. The resident's diagnoses                 |      |          | Plan initiated. The QAPI  |                |            |
|  |  | not limited to, acute kidney                |      |          | committee will determine when   |                |            |
|  | failure and hyperter   | ision.                                      |      |          | 100% compliance is achieved   |                |            |
|  | The care plan dated  | d 9/7/21, indicated the resident            |      |          | ongoing monitoring is required  | 1.             |            |
|  | _  | nd staff were to administer the             |      |          |   |                |            |
|  |  | ons as ordered by the medical               |      |          |   |                |            |
|  | provider.  | ,   |      |          |   |                |            |
|  | •  |   |      |          |   |                |            |
|  | The physician's ord  | er, dated 3/18/24, indicated the            |      |          |   |                |            |
|  | resident was to rece   | ive Hydralazine 100 mg three                |      |          |   |                |            |
|  | -  | a.m., 4:00 p.m. and 11:00 p.m.              |      |          |   |                |            |
|  |  | he resident's medication was                |      |          |   |                |            |
|  | -  | f the resident's systolic blood             |      |          |   |                |            |
|  | pressure was less th   | an 110.                                     |      |          |   |                |            |
|  | Review of the June   | 2024 medication administration              |      |          |   |                |            |
|  |  | e resident received the                     |      |          |   |                |            |
|  |  | ollowing dates and times:                   |      |          |   |                |            |
|  |  |   |      |          |   |                |            |
|  | On 6/3/24 at 11:00   | a.m., the resident's systolic               |      |          |   |                |            |
|  | blood pressure was   |   |      |          |   |                |            |
|  | On 6/4/24 at 4:00 p  | .m., the resident's systolic                |      |          |   |                |            |

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| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155657 |  | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING  | ONSTRUCTION  00 | (X3) DATE SURVEY COMPLETED 06/10/2024   |      |                    |
|--|--|---|-----------------|---|------|--------------------|
|  | ROVIDER OR SUPPLIER  |   | 150 BE          | ADDRESS, CITY, STATE, ZIP COD<br>ECHMONT DR<br>DON, IN 47112                                      | -    |                    |
| (X4) ID<br>PREFIX  | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LL SC IDENTIFYING DIFFORMATION   | ID<br>PREFIX    | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY) | D BE | (X5)<br>COMPLETION |
|  | blood pressure was On 6/5/24 at 4:00 p blood pressure was The physician's ord resident was to recet twice a day at 11:00 hypertension. The rheld by staff if the rpressure was less than 60 Review of the May record indicated the medication on the form on 5/01/24 at 11:00 55.  On 5/02/244 at 11:00 55.  On 5/03/24 at 11:00 55.  On 5/05/24 at 11:00 55.  On 5/05/24 at 11:00 55.  On 5/06/24 at 11:00 55.  On 5/07/24 at 11:00 55.  On 5/06/24 at 11:00 56.  On 5/07/24 at 11:00 57.  On 5/07/24 at 11:00 57.  On 5/07/24 at 11:00 59.  Review of the June record indicated the medication on 6/3/2 blood pressure of 10 4. The clinical record on 6/8/24 at 2:13 p. | CY MUST BE PRECEDED BY FULL LESC IDENTIFYING INFORMATION 107.  .m., the resident's systolic 106.  er, dated 3/7/24, indicated the live Metoprolol Tartrate 25 mg 0 a.m. and 11:00 p.m. for esident's medication was to be resident's systolic blood an 110 or the resident's pulse 0.  2024 medication administration resident received the follow dates and times: 0 p.m., the resident's pulse was 1., the resident's pulse was 2., the resident's pulse was 3., the resident's pulse was 4., the resident's pulse was 5., p.m., the resident's pulse was 6., p.m., the resident's pulse was 7., p.m., the resident's pulse was 8., p.m., the resident's pulse was 9 p.m., the resident's pulse was 10 p.m., the resident's pulse was 11 p.m., the resident's pulse was 12 p.m., the resident's pulse was 13 p.m., the resident's pulse was 14 p.m., the resident received the 15 p.m., the resident received the 16 p.m., the resident received the 17 p.m., the resident received the 18 p.m., the resident received the 19 p.m., the resident received the |                 | (EACH CORRECTIVE ACTION SHOUL   | D BE |                    |
|  | hypertension.  | 1 8/16/22, indicated the  |                 |   |      |                    |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                        | (X2) M                            | ULTIPLE CO | NSTRUCTION | (X3) DATE  | SURVEY |            |
|--|------------------------|-----------------------------------|------------|------------|--|--------|------------|
| AND PLAN   | OF CORRECTION          | IDENTIFICATION NUMBER             | A. BU      | JILDING    | 00   | COMPL  | ETED       |
|  |                        | 155657                            | B. W       | ING        |  | 06/10/ | 2024       |
|  |                        |                                   |            | CTREET     | DDDECC CITY CTATE ZID COD  |        |            |
| NAME OF P  | ROVIDER OR SUPPLIER    | 8                                 |            |            | ADDRESS, CITY, STATE, ZIP COD  |        | l          |
| LIADDICA   |                        | CENTED                            |            |            | ECHMONT DR   |        |            |
| HARRIS   | ON HEALTHCARE          | CENTER                            |            | CORYL      | OON, 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<br>CROSS-REFERENCED TO THE APPROPRIA | TE     | COMPLETION |
| TAG  | REGULATORY OR          | R LSC IDENTIFYING INFORMATION     |            | TAG        | DEFICIENCY)  | 16     | DATE       |
|  |                        | ension and staff were to          |            |            |  |        |            |
|  |                        | lent's medications as ordered     |            |            |  |        |            |
|  | by the medical prov    |                                   |            |            |  |        |            |
|  | 1                      |                                   |            |            |  |        |            |
|  | The physicians' ord    | er, dated 10/25/22, indicated     |            |            |  |        |            |
|  |                        | receive Carvedilol 6/25 mg        |            |            |  |        |            |
|  |                        | nypertension. The medication      |            |            |  |        |            |
|  |                        | taff if the resident's systolic   |            |            |  |        |            |
|  | blood pressure was     | <del>-</del>                      |            |            |  |        |            |
|  | 1 122322               | -                                 |            |            |  |        |            |
|  | Review of the May      | 2024 and June 2024 medication     |            |            |  |        |            |
|  |                        | rd lacked documentation of a      |            |            |  |        |            |
|  | recorded blood pres    |                                   |            |            |  |        |            |
|  | _                      | ne medication, on the following   |            |            |  |        |            |
|  | dates:                 | to moureuren, on the Tene wing    |            |            |  |        |            |
|  | uures.                 |                                   |            |            |  |        |            |
|  | 5/02/24                |                                   |            |            |  |        |            |
|  | 5/07/24 through 5/0    | 09/24                             |            |            |  |        |            |
|  | 5/14/24 -through 5/    |                                   |            |            |  |        |            |
|  | 5/20/24                | 10,21                             |            |            |  |        |            |
|  | 5/22/24 and 5/23/24    | 1                                 |            |            |  |        |            |
|  | 5/28/24                | •                                 |            |            |  |        |            |
|  | 5/30/24                |                                   |            |            |  |        |            |
|  | 6/01/24                |                                   |            |            |  |        |            |
|  | 6/04/24 through 6/0    | 06/24                             |            |            |  |        |            |
|  | oro-re- unough 0/0     | 1012 f                            |            |            |  |        |            |
|  | On 6/9/2/Lat 12:55     | p.m., the RDCO (Regional          |            |            |  |        |            |
|  |                        | Operations) provided a            |            |            |  |        |            |
|  |                        | py of the document titled         |            |            |  |        |            |
|  |                        | nistration". It included, but was |            |            |  |        |            |
|  |                        | icyIt is the policy of this       |            |            |  |        |            |
|  | ·                      |                                   |            |            |  |        |            |
|  |                        | esident centered careSafety       |            |            |  |        |            |
|  |                        | p priority of careAdminister      |            |            |  |        |            |
|  | medication only as     |                                   |            |            |  |        |            |
|  | _                      | ertinent information prior to     |            |            |  |        |            |
|  |                        | .Blood pressureApical             |            |            |  |        |            |
|  | pulse"                 |                                   |            |            |  |        |            |
|  | TILL CITY I            | G 1 : DIO 12 1005                 |            |            |  |        |            |
|  | I his Citation relates | s to Complaint IN00434995         |            |            |  |        |            |
|  |                        |                                   |            |            |  |        |            |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155657  | A. BU | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING                        |  | (X3) DATE SURVEY  COMPLETED  06/10/2024  |                            |
|--|--|--|-------|---|--|--|----------------------------|
|  | IDER OR SUPPLIER   |  |       | STREET ADDRESS, CITY, STATE, ZIP COD 150 BEECHMONT DR CORYDON, IN 47112 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION  |       | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)  | ATE                                      | (X5)<br>COMPLETION<br>DATE |
| F 0695 SS=D Bldg. 00 Su § 4 tra Th nee tra is p pro coi the 48: Ba rev equ res C, Fir  1. ' on inc sta  Du res ey a s wit coi on Th we | 3.25(i) espiratory/Trach espiratory/Trach estioning 483.25(i) Respiratory cheostomy care e facility must e eds respiratory cheostomy care provided such cofessional standamprehensive per esidents' goal 3.65 of this subsed on observationiem, the facility suipment was baggidents reviewed in D and E) and E) and E) and E) and E clinical record 6/8/24 at 1:11 publication matching estident was observed as open and a trace of the a yankauer (or nnected to it. The the night stand and the physician's order. | eostomy Care and atory care, including and tracheal suctioning. ensure that a resident who care, including and tracheal suctioning, eare, consistent with lards of practice, the erson-centered care plan, is and preferences, and part. on, interview, and record failed to ensure respiratory ged, when not in use, for 3 of 3 for respiratory care. (Residents  and for Resident C was reviewed m. The resident's diagnosis of limited to, tracheostomy  and on 6/8/24 at 10:27 a.m., the ed resting in bed with her cheostomy in place. There was on the resident's night stand al suctioning tool) and tubing e yankauer was lying directly and not in a bag.  er, dated 6/6/24, indicated staff resident's tracheotomy every | F 06  |   | Preparation or execution of the plan of correction does not constitute admission or agree of provider of the truth of the falleged or conclusions set for the State of Deficiencies. The of Correction is prepared and executed solely because it is required by the position of Ferand State Law.  The Plan of Correction is submitted in order to respond the allegation of noncomplian cited during the survey condu June 10, 2024. Please accept this plan of correction as the provider's credible allegation of compliance.  The facility would like to respectfully request a desk respectfully request | ment facts th on Plan deral to ce cted t | 07/09/2024                 |

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Event ID:

JN3O11 Facili

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If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |  | (X2) MULTIPLE CONSTRUCTION           |          | ONSTRUCTION | (X3) DATE SURVEY  |          |            |
|--|--|--------------------------------------|----------|-------------|---|----------|------------|
| AND PLAN   | OF CORRECTION                                | IDENTIFICATION NUMBER                | A. BU    | JILDING     | 00  | COMPL    | ETED       |
|  |  | 155657                               | B. W     | ING         |   | 06/10/   | /2024      |
|  |  | l                                    | <u> </u> | STDEET /    | ADDRESS, CITY, STATE, ZIP COD                                       | <u> </u> |            |
| NAME OF P  | PROVIDER OR SUPPLIEF                         | ₹                                    |          |             | ECHMONT DR  |          |            |
| UADDIQ/  | ON HEALTHCARE                                | CENTED                               |          |             | OON, IN 47112   |          |            |
| HARRIS   | JIN FIEAL I FIGARE                           | CENTER                               |          | CORTL       | JOIN, IIN 47 I IZ   |          |            |
| (X4) ID  | SUMMARY                                      | STATEMENT OF DEFICIENCIE             |          | ID          | PROVIDER'S PLAN OF CORRECTION                                       |          | (X5)       |
| PREFIX   | (EACH DEFICIEN                               | ICY MUST BE PRECEDED BY FULL         |          | PREFIX      | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE       | COMPLETION |
| TAG  | REGULATORY OF                                | R LSC IDENTIFYING INFORMATION        | <u> </u> | TAG         | DEFICIENCY)   |          | DATE       |
|  |  | 9 a.m., LPN (Licensed Practical      |          |             | affected by the deficient practi                                    | ce:      |            |
|  | Nurse) 6 indicated respiratory equipment and |                                      |          |             | Residents C, D and E were no  |          |            |
|  | suctioning yankauers, should be bagged when  |                                      |          |             | harmed by the alleged deficien                                      | nt       |            |
|  | not in use due to ge                         | erms and infection control.          |          |             | practice. Residents C, D, and                                       | E        |            |
|  |  |                                      |          |             | were part of a confidential sur                                     | vey      |            |
|  |  | rd for Resident D was reviewed       |          |             | and therefore not identified.                                       |          |            |
|  |  | m. The resident's diagnoses          |          |             |   |          |            |
|  | •  | not limited to, congestive heart     |          |             | STEP 2 Corrective action take                                       | n for    |            |
|  | failure and asthma.                          |                                      |          |             | those residents having the  |          |            |
|  |  |                                      |          |             | potential to be affected by the                                     |          |            |
|  | _  | ion on 6/7/24 at 11:06 a.m.,         |          |             | same deficient practice:  |          |            |
|  |  | er machine sitting in the            |          |             | All residents who utilize   |          |            |
|  |  | vith tubing attached to a hand       |          |             | respiratory equipment could b                                       |          |            |
|  |  | hand held nebulizer was lying        |          |             | affected by the alleged deficie                                     |          |            |
|  |  | not bagged. The nebulizer            |          |             | practice. An audit of all rooms                                     |          |            |
|  | machine was not in                           | use.                                 |          |             | resident who utilize respiratory                                    | /        |            |
|  |  |                                      |          |             | equipment was completed to  |          |            |
|  |  | ler, dated 3/18/24, indicated the    |          |             | ensure equipment was proper   | ly       |            |
|  |  | eive ipratropium-albuterol           |          |             | stored or disposed of any   |          |            |
|  | _  | g (milligrams)/ml (milliliter), 3 ml |          |             | concerns were immediately   |          |            |
|  |  | ation three times a day for          |          |             | addressed.  |          |            |
|  | wheezing.                                    |                                      |          |             |   |          |            |
|  |  |                                      |          |             | STEP 3 Measures/systemic  |          |            |
|  | _  | rd for Resident E was reviewed       |          |             | changes put into place to ensu                                      |          |            |
|  | _  | m. The resident's diagnoses          |          |             | the deficient practice does not                                     |          |            |
|  |  | not limited to, chronic              |          |             | recur:  |          |            |
|  | 1 . 1  | ary disease, chronic                 |          |             | The DON/Designee held an  |          |            |
|  | respiratory failure a                        | and congestive heart failure.        |          |             | in-service for all nurses to pro                                    |          |            |
|  | <u> </u>                                     |                                      |          |             | education and expectations as                                       | s it     |            |
|  | _  | ion on 6/7/24 at 11:06 a.m.,         |          |             | relates to the "Nebulizer   |          |            |
|  |  | er machine sitting in the            |          |             | Treatments" policy and proceed                                      |          |            |
|  |  | the tubing attached to a hand        |          |             | including the proper storage a                                      |          |            |
|  |  | hand held nebulizer was not          |          |             | disposal of respiratory equipm                                      | ent.     |            |
|  | being used or in a b                         | oag.                                 |          |             | 0.755.4.0   |          |            |
|  |  | 1 . 15/02/04                         |          |             | STEP 4 Corrective actions to  |          |            |
|  |  | ler, dated 5/23/24, indicated the    |          |             | monitored to ensure the defici                                      | ent      |            |
|  |  | eive ipratropium-albuterol           |          |             | practice will not recur:  | _        |            |
|  | _  | g (milligrams)/ml (milliliter), 3 ml |          |             | The DON/Designee will audit   |          |            |
|  |  | ation three times a day for          |          |             | residents a week x 4 weeks, the                                     |          |            |
|  | congestion.                                  |                                      |          |             | 3 residents for week x 4 week                                       | S.       |            |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |  | (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR  |   |   | SURVEY  |   |            |
|--|--|---|---|---|---|---|------------|
| AND PLAN   | OF CORRECTION  | IDENTIFICATION NUMBER   |   | JILDING   | 00  | COMPL   |            |
|  |  | 155657  | B. WI   | NG  |   | 06/10/  | 2024       |
|  | PROVIDER OR SUPPLIER   |   | STREET ADDRESS, CITY, STATE, ZIP COD 150 BEECHMONT DR CORYDON, IN 47112 |   |   |   |            |
| (X4) ID  | SUMMARY  | STATEMENT OF DEFICIENCIE  |   | ID  | PROVIDED'S DI AN OF CORRECTION  |   | (X5)       |
| PREFIX   | (EACH DEFICIEN   | CY MUST BE PRECEDED BY FULL   |   | PREFIX  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA   | TE  | COMPLETION |
| TAG  | REGULATORY OR  | LSC IDENTIFYING INFORMATION   |   | TAG   | DEFICIENCY)   |   | DATE       |
|  | Clinical Operations copy of the docume Treatments". It inch "PolicyIt is the poresident centered catop priority of care  This Citation relates 3.1-47(a)(6)  | uded, but was not limited to,<br>licy of this facility to provide<br>reSafety of residentsis a  |   | then 1 resident a week x 4 weeks for no less than 3 months and compliance is maintained to ensure proper storage/disposal of respiratory equipment.  The DON/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. |   | al of<br>nt<br>nthly<br>ess<br>hat<br>on<br>or if         |            |
| F 0921<br>SS=E<br>Bldg. 00                           | §483.90(i) Other E The facility must p sanitary, and com residents, staff an Based on observation review, the facility e environment for 2 of Hall and 300 Hall)  Findings include:  1. Upon facility ent a.m. and 10:55 a.m. the 300 Hallway:  At 10:27 a.m., in Ro and a bath blanket of and air unit in Room across from the 2nd brown substance stu substance had a stro | anitary/Comfortable Environ Environmental Conditions rovide a safe, functional, fortable environment for d the public.  In interview and record failed to maintain a sanitary f 3 Hallways observed. (200  Trance on 6/8/24, between 10:16 the following was observed on the floor under the heating in 310. The bedside commode, bed, had a dried, speckled tack on the commode seat. The torg odor of stool. The tof order sign posted on it. | F 09  | 921   | Preparation or execution of thi plan of correction does not constitute admission or agreer of provider of the truth of the fa alleged or conclusions set fort the State of Deficiencies. The of Correction is prepared and executed solely because it is required by the position of Fed and State Law.  The Plan of Correction is submitted in order to respond the allegation of noncompliance cited during the survey conductive June 10, 2024. Please accept this plan of correction as the provider's credible allegation of compliance. | ment<br>acts<br>h on<br>Plan<br>deral<br>to<br>be<br>cted | 07/09/2024 |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                         |                                  | (X2) MULTIPLE CONSTRUCTION |                        |  | (X3) DATE SURVEY |            |
|--|-------------------------|----------------------------------|----------------------------|------------------------|--|------------------|------------|
|  |                         |                                  |                            |                        |  | · ′              |            |
| AND PLAN   | OF CORRECTION           | IDENTIFICATION NUMBER            |                            | UILDING                | 00   | COMPLETED        |            |
|  |                         | 155657                           | B. W                       | ING                    |  | 06/10/           | 2024       |
| NAME OF P  | ROVIDER OR SUPPLIEF     |                                  |                            |                        | ADDRESS, CITY, STATE, ZIP COD  |                  |            |
|  |                         |                                  |                            |                        | ECHMONT DR   |                  |            |
| HARRISO  | ON HEALTHCARE           | CENTER                           |                            | CORYE                  | OON, IN 47112  |                  |            |
| (X4) ID  | SUMMARY                 | STATEMENT OF DEFICIENCIE         |                            | ID                     | PROVIDER'S PLAN OF CORRECTION  |                  | (X5)       |
| PREFIX   | (EACH DEFICIEN          | ICY MUST BE PRECEDED BY FULL     |                            | PREFIX                 | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE               | COMPLETION |
| TAG  | REGULATORY OF           | R LSC IDENTIFYING INFORMATION    |                            | TAG                    | DEFICIENCY)  |                  | DATE       |
|  |                         |                                  |                            |                        | The facility would like to   |                  |            |
|  | At 10:36 a.m., Room     | m 313 had 2 towels on the floor, |                            |                        | respectfully request a desk re   | view.            |            |
|  | to the left of the bat  | throom door. An out of order     |                            |                        | Brandon Jensen, LNHA   |                  |            |
|  | sign was posted on      | the bathroom door. There was     |                            |                        |  |                  |            |
|  | a strong urine odor     | in the bathroom and the floor    |                            |                        |  |                  |            |
|  | had a puddle of wat     | ter next to the toilet. A brown  |                            |                        | STEP 1 Corrective action for t   | he               |            |
|  | -                       | rved on the toilet seat and on   |                            |                        | residents found to have been   |                  |            |
|  |                         | of the toilet. The piping from   |                            |                        | affected by the deficient practi                                       | ice:             |            |
|  |                         | et had been removed and was      |                            |                        | No resident was harmed by the  |                  |            |
|  |                         | hroom floor. The trash can by    |                            |                        | alleged deficient practice. All  |                  |            |
|  |                         | out of reach and without a       |                            |                        | environmental concerns were  |                  |            |
|  |                         | as an empty chocolate milk       |                            |                        | immediately addressed.   |                  |            |
|  | -                       | 2 plastic lids, unopened jelly   |                            |                        | Ininiediately addressed.   |                  |            |
|  |                         | er next to the bed on the floor. |                            |                        | STEP 2 Corrective action take  | n for            |            |
|  | and a snack wrappe      | i liext to the bed on the hoor.  |                            |                        | -  | 11 101           |            |
|  | 0:. (/9/24 -4 10:41     | DN (D: N) 5                      |                            |                        | those residents having the   |                  |            |
|  |                         | a.m., RN (Register Nurse) 5      |                            |                        | potential to be affected by the  |                  |            |
|  | _                       | ipe had collapsed and            |                            |                        | same deficient practice:   |                  |            |
|  | _                       | ne building working on it last   |                            |                        | All residents who reside at the  |                  |            |
|  | _                       | e coming back today. She did     |                            |                        | facility could be affected by th                                       |                  |            |
|  |                         | and was unsure why the           |                            |                        | alleged deficient practice. An   | audit            |            |
|  | bathroom looked lil     | ke it did.                       |                            |                        | of all resident areas was  |                  |            |
|  |                         |                                  |                            |                        | completed to ensure a sanitar  | -                |            |
|  |                         | Room 313, there was a large shop |                            |                        | environment any concerns we  | re               |            |
|  | vac sitting next to the | he wall in the hallway.          |                            |                        | immediately addressed.   |                  |            |
|  | During an interview     | v on 6/8/24 at 11:55 a.m., the   |                            |                        | STEP 3 Measures/systemic   |                  |            |
|  | _                       | eated the contractors had left   |                            | changes put into place |  | ıre              |            |
|  | the shop vac in the     |                                  |                            |                        | the deficient practice does not  |                  |            |
|  | and shop vac in the     |                                  |                            |                        | recur:   | <u>.</u>         |            |
|  | At 10:44 am asm         | all puddle of water was          |                            |                        | The ED/Designee held an  |                  |            |
|  |                         | t side of bed 2 with an empty    |                            |                        | in-service for all direct care sta                                     | off to           |            |
|  |                         | floor. On bed 2's bed side       |                            |                        | provide education and  | aii lU           |            |
|  | -                       |                                  |                            |                        | ·  |                  |            |
|  |                         | end of the bed, sat a can of air |                            |                        | expectations as it relates to  | _                |            |
|  | freshener.              |                                  |                            |                        | infection control and sanitation                                       |                  |            |
|  | D                       | C/9/24 + 10.57 - 1               |                            |                        | practices including the prompt   |                  |            |
|  | _                       | v on 6/8/24 at 10:55 a.m., the   |                            |                        | response to water/spills, prope  | er               |            |
|  |                         | rk indicated the can of air      |                            |                        | disposal of trash, linen   |                  |            |
|  |                         | uld not have been in the         |                            |                        | management, bedside commo  |                  |            |
|  | resident's room as i    | t was a chemical.                |                            |                        | maintenance equipment in ha  | lls,             |            |
|  |                         |                                  |                            |                        | aerosol cans and general   |                  |            |

JN3011

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

PRINTED: 08/12/2024 FORM APPROVED OMB NO. 0938-039

| CE.TERO I OF | THE CONTENTS         | THE SELL TOLLS                        |                  |  |             | 21101020007 |  |
|--------------|----------------------|---------------------------------------|------------------|--|-------------|-------------|--|
| STATEMEN     | T OF DEFICIENCIES    | X1) PROVIDER/SUPPLIER/CLIA            | (X2) MULTIPLE CO | ONSTRUCTION  | (X3) DATE S | SURVEY      |  |
| AND PLAN     | OF CORRECTION        | IDENTIFICATION NUMBER                 | A. BUILDING      | 00   | COMPL       | ETED        |  |
|              |                      | 155657                                | B. WING          |  | 06/10/      | 2024        |  |
|              |                      |                                       |                  |  | 33, 10,     |             |  |
| NAME OF F    | PROVIDER OR SUPPLIER |                                       |                  | ADDRESS, CITY, STATE, ZIP COD  |             |             |  |
| TWINE OF I   | NO VIDER OR SETTEM   |                                       | 150 BE           | ECHMONT DR   |             |             |  |
| HARRIS       | ON HEALTHCARE        | CENTER                                | CORYI            | DON, IN 47112  |             |             |  |
| (X4) ID      | SUMMARY              | STATEMENT OF DEFICIENCIE              | ID               | PROVIDER'S PLAN OF CORRECTION  |             | (X5)        |  |
| PREFIX       | (EACH DEFICIEN       | NCY MUST BE PRECEDED BY FULL          | PREFIX           | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | ATE         | COMPLETION  |  |
| TAG          | REGULATORY OF        | R LSC IDENTIFYING INFORMATION         | TAG              | DEFICIENCY)  |             | DATE        |  |
|              | 2. On 6/8/24, betwee | een 10:58 a.m. and 11:12 a.m., the    |                  | sanitation in resident areas.  |             |             |  |
|              | following was obse   | erved on the 200 Hallway:             |                  |  |             |             |  |
|              |                      |                                       |                  | STEP 4 Corrective actions to   | be          |             |  |
|              | At 11:00 a.m., bed   | linens were observed on the           |                  | monitored to ensure the defic  | ient I      |             |  |
|              |                      | ped A in Room 215. The                |                  | practice will not recur:   |             |             |  |
|              |                      | commode was next to the               |                  | The ED/Designee will audit a   | ıll İ       |             |  |
|              |                      | nmode was observed with urine         |                  | resident areas 5 days a week   |             |             |  |
|              |                      | l a quarter of the way full.          |                  | weeks, then 3 days a week for  |             |             |  |
|              | and pup of the       | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 |                  | week x 4 weeks, then 1 day a   |             |             |  |
|              | During an interviev  | v on 6/10/24 at 11:10 a.m., CNA       |                  | week x 4 weeks for no less than 3                                      |             |             |  |
|              |                      | Aide) 8 indicated it was not          |                  | months and compliance is   |             |             |  |
|              | `                    | ed linens to be on the floor.         |                  | maintained to ensure proper  |             |             |  |
|              |                      |                                       |                  | 1  |             |             |  |
|              |                      | agged and placed in the dirty         |                  | sanitation practices are in pla  | ce.         |             |  |
|              |                      | dside commodes, she assumed,          |                  |  |             |             |  |
|              |                      | every 2 hours and emptied like        |                  | The ED/Designee will present   |             |             |  |
|              | a bed check.         |                                       |                  | results of these audits monthl   | •           |             |  |
|              |                      |                                       |                  | the QAPI committee for no les  |             |             |  |
|              |                      | p.m., the Regional Director of        |                  | than 3 months. Any patterns  |             |             |  |
|              | Clinical Operations  | s provided a current copy of the      |                  | are identified will have an Act  | ion         |             |  |
|              | document titled "In  | fection Control Practices for         |                  | Plan initiated. The QAPI   |             |             |  |
|              | Laundry/Linen" dat   | ted 10/29/13. It included, but        |                  | committee will determine whe   | n           |             |  |
|              |                      | "PolicyIt is the policy of this       |                  | 100% compliance is achieved  | or if       |             |  |
|              |                      | resident centered careThe             |                  | ongoing monitoring is require  |             |             |  |
|              | safety of residents  |                                       |                  |  |             |             |  |
|              | consideration"       |                                       |                  |  |             |             |  |
|              | consideration        |                                       |                  |  |             |             |  |
|              | This Citation relate | s to Complaint IN00434995             |                  |  |             |             |  |
|              | 3.1-19(a)(4)         |                                       |                  |  |             |             |  |
|              | 3.1-19(f)(5)         |                                       |                  |  |             |             |  |
|              | 3.1-19(g)(1)         |                                       |                  |  |             |             |  |

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