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	06/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00434995. Complaint IN00434995 - Federal/State deficiencies related to the allegations are cited at F684, F695 and F921. Survey dates: June 8, 9 and 10, 2024 Facility number: 010597 Provider number: 155657 AIM number: 200204440 Census Bed Type: SNF/NF: 83 Total: 83 Census Payor Type: Medicare: 4 Medicaid: 45 Other: 34 Total: 83 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 17, 2024.	F 0000	**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 survey conducted 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 review.** **Brandon Jensen, LNHA**	
F 0684 SS=E Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with			

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

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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	professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to ensure monitoring was in place for a resident (Resident B) with a chole drain and to ensure the nursing staff followed medication parameters (Resident B, C, D and E) for 4 of 5 residents reviewed for quality of care. Findings include: 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. The nurse practitioner note, dated 5/20/24 at 12:50 p.m., indicated the resident supposedly admitted with a chole drain in the right side, however, there was only a short suture hanging from her bed. The drain was either accidentally pulled our or it fell out. The clinical record lacked documentation of any monitoring of the resident's chole drain between	F 0684	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 survey conducted 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 review. Brandon Jensen, LNHA STEP 1 Corrective action for the residents found to have been affected by the deficient practice: Residents B, C, D and E were not harmed by the alleged deficient practice. Residents B,C, D, and E were part of a confidential survey and therefore not identified. STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice: All residents who have orders with blood pressure parameters or a	07/09/2024

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	5/17/24 at 1:51 p.m. and 5/20/24 at 12:50 p.m. when it was observed not in place by the nurse practitioner. During an interview on 6/10/24 at 10:47 a.m., the Director of Nursing indicated the staff should have been monitoring the resident's drain. 1.b. The physician's order, dated 5/18/24, indicated Resident B was to receive Metoprolol Succinate ER (extended release), 100 mg (milligrams) daily for arrhythmia. Staff were to hold the resident's medication if the resident's systolic blood pressure was less than 110 or the resident's pulse was less than 60. Review of the May 2024 medication administration record indicated the resident's systolic blood pressure was 108 and the medication was administered. During an interview on 6/9/24 at 11:30 a.m., RN (Registered Nurse) 5 indicated if a resident's blood pressure was not within the parameters listed, the medication should be held and blood pressure should be obtained prior to the administration of the medication. 2. The clinical record for Resident C was reviewed on 6/8/24 at 1:11 p.m. The resident's diagnosis included, but was not limited to, orthostatic hypotension. The physician's order, dated 5/30/24, indicated the resident was to receive Midodrine HCl (hydrochloride) 10 mg three times a day at 8:00 a.m., 12:00 p.m. and 4:00 p.m. for hypotension (low blood pressure). The resident's medication was to be held if the resident's systolic blood pressure was greater than 120.		chole drain could be affected by the alleged deficient practice. A 30-day lookback of all medications with blood pressure parameters was completed to ensure medications had been administered according to physicians' orders. A 30-day lookback of all admissions was completed to ensure proper monitoring was in place for any residents with chole drains. Any concerns were immediately addressed. STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur: The DON/Designee held an in-service for all nurses to provide education and expectations as it relates to the "medication administration" policy and procedures including administering blood pressure medication with parameters according to physician orders. The DON/Designee held an in-service for all nurses to provide education and expectations as it relates to the monitoring of chole drains. STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur: The DON/Designee will audit 5 residents a week x 4 weeks, then 3 residents for week x 4 weeks, then 1 resident a week x 4 weeks	

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	Review of the June 2024 medication administration record indicated the medication was administered on the following dates and times: On 6/4/24 at 8:00 a.m. , the resident's systolic blood pressure was 130. On 6/4/24 at 12:00 p.m., the resident's systolic blood pressure was 126. On 6/4/24 at 4:00 p.m., the resident's systolic blood pressure was 125. On 6/5/24 at 12:00 p.m., the resident's systolic blood pressure was 122. On 6/6/24 at 8:00 a.m., the resident's systolic blood pressure was 141. 3. The clinical record for Resident D was reviewed on 6/8/24 at 1:44 p.m. The resident's diagnoses included, but were not limited to, acute kidney failure and hypertension. The care plan, dated 9/7/21, indicated the resident had hypertension and staff were to administer the resident's medications as ordered by the medical provider. The physician's order, dated 3/18/24, indicated the resident was to receive Hydralazine 100 mg three times a day at 11:00 a.m., 4:00 p.m. and 11:00 p.m. for hypertension. The resident's medication was to be held by staff if the resident's systolic blood pressure was less than 110. Review of the June 2024 medication administration record indicated the resident received the medication on the following dates and times: On 6/3/24 at 11:00 a.m., the resident's systolic blood pressure was 102. On 6/4/24 at 4:00 p.m., the resident's systolic		for no less than 3 months and compliance is maintained to ensure blood pressure medication with parameters are administered per physician order. The DON/Designee will audit all new admissions for no less than 3 months and compliance is maintained to ensure monitoring is in place for any resident admitting with a chole drain. 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.	

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	blood pressure was 107. On 6/5/24 at 4:00 p.m., the resident's systolic blood pressure was 106. The physician's order, dated 3/7/24, indicated the resident was to receive Metoprolol Tartrate 25 mg twice a day at 11:00 a.m. and 11:00 p.m. for hypertension. The resident's medication was to be held by staff if the resident's systolic blood pressure was less than 110 or the resident's pulse rate was less than 60. Review of the May 2024 medication administration record indicated the resident received the medication on the follow dates and times: On 5/01/24 at 11:00 p.m., the resident's pulse was 55. On 5/02/244 at 11:00 a.m., the resident's pulse was 57 and at 11:00 p.m., the resident's pulse was 58. On 5/03/24 at 11:00 p.m., the resident's pulse was 55. On 5/05/24 at 11:00 p.m., the resident's pulse was 56. On 5/06/24 at 11:00 p.m., the resident's pulse was 57. On 5/07/24 at 11:00 p.m., the resident's pulse was 59. Review of the June 2024 medication administration record indicated the resident received the medication on 6/3/24 at 11:00 a.m. with a systolic blood pressure of 102. 4. The clinical record for Resident E was reviewed on 6/8/24 at 2:13 p.m. The resident's diagnoses included, but were not limited to, heart failure and hypertension. The care plan, dated 8/16/22, indicated the			

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	resident had hypertension and staff were to administer the resident's medications as ordered by the medical provider. The physicians' order, dated 10/25/22, indicated the resident was to receive Carvedilol 6/25 mg every morning for hypertension. The medication was to be held by staff if the resident's systolic blood pressure was less than 110. Review of the May 2024 and June 2024 medication administration record lacked documentation of a recorded blood pressure, prior to the administration of the medication, on the following dates: 5/02/24 5/07/24 through 5/09/24 5/14/24 -through 5/16/24 5/20/24 5/22/24 and 5/23/24 5/28/24 5/30/24 6/01/24 6/04/24 through 6/06/24 On 6/9/24 at 12:55 p.m., the RDCO (Regional Director of Clinical Operations) provided a current, undated copy of the document titled "Medication Administration". It included, but was not limited to, "Policy...It is the policy of this facility to provide resident centered care...Safety of residents...is a top priority of care...Administer medication only as prescribed by the provider...Record pertinent information prior to giving medication...Blood pressure...Apical pulse...." This Citation relates to Complaint IN00434995			

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	3.1-37			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure respiratory equipment was bagged, when not in use, for 3 of 3 residents reviewed for respiratory care. (Residents C, D and E) Findings include: 1. The clinical record for Resident C was reviewed on 6/8/24 at 1:11 p.m. The resident's diagnosis included, but was not limited to, tracheostomy status. During an observation on 6/8/24 at 10:27 a.m., the resident was observed resting in bed with her eyes open and a tracheostomy in place. There was a suction matching on the resident's night stand with a yankauer (oral suctioning tool) and tubing connected to it. The yankauer was lying directly on the night stand and not in a bag. The physician's order, dated 6/6/24, indicated staff were to suction the resident's tracheotomy every shift and as needed.	F 0695	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 survey conducted 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 review. Brandon Jensen, LNHA STEP 1 Corrective action for the residents found to have been	07/09/2024

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	On 6/10/24 at 10:49 a.m., LPN (Licensed Practical Nurse) 6 indicated respiratory equipment and suctioning yankauers, should be bagged when not in use due to germs and infection control. 2. The clinical record for Resident D was reviewed on 6/8/24 at 1:44 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure and asthma. During an observation on 6/7/24 at 11:06 a.m., there was a nebulizer machine sitting in the resident's recliner with tubing attached to a hand held nebulizer. The hand held nebulizer was lying on the recliner and not bagged. The nebulizer machine was not in use. The physician's order, dated 3/18/24, indicated the resident was to receive ipratropium-albuterol solution 0.5-2.5 mg (milligrams)/ml (milliliter), 3 ml via nebulizer inhalation three times a day for wheezing. 3. The clinical record for Resident E was reviewed on 6/8/24 at 2:13 p.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, chronic respiratory failure and congestive heart failure. \ During an observation on 6/7/24 at 11:06 a.m., there was a nebulizer machine sitting in the resident's bed with the tubing attached to a hand held nebulizer. The hand held nebulizer was not being used or in a bag. The physician's order, dated 5/23/24, indicated the resident was to receive ipratropium-albuterol solution 0.5-2.5 mg (milligrams)/ml (milliliter), 3 ml via nebulizer inhalation three times a day for congestion.		affected by the deficient practice: Residents C, D and E were not harmed by the alleged deficient practice. Residents C, D, and E were part of a confidential survey and therefore not identified. STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice: All residents who utilize respiratory equipment could be affected by the alleged deficient practice. An audit of all rooms of resident who utilize respiratory equipment was completed to ensure equipment was properly stored or disposed of any concerns were immediately addressed. STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur: The DON/Designee held an in-service for all nurses to provide education and expectations as it relates to the “Nebulizer Treatments” policy and procedures including the proper storage and disposal of respiratory equipment. STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur: The DON/Designee will audit 5 residents a week x 4 weeks, then 3 residents for week x 4 weeks,	

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	On 6/10/24 at 10:58 a.m., the Regional Director of Clinical Operations provided an undated, current copy of the document titled "Nebulizer Treatments". It included, but was not limited to, "Policy...It is the policy of this facility to provide resident centered care...Safety of residents...is a top priority of care...." This Citation relates to Complaint IN00434995 3.1-47(a)(6)		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.	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to maintain a sanitary environment for 2 of 3 Hallways observed. (200 Hall and 300 Hall) Findings include: 1. Upon facility entrance on 6/8/24, between 10:16 a.m. and 10:55 a.m., the following was observed on the 300 Hallway: At 10:27 a.m., in Room 310, there were 2 towels and a bath blanket on the floor under the heating and air unit in Room 310. The bedside commode, across from the 2nd bed, had a dried, speckled brown substance stuck on the commode seat. The substance had a strong odor of stool. The bathroom had an out of order sign posted on it.	F 0921	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 survey conducted June 10, 2024. Please accept this plan of correction as the provider's credible allegation of compliance.	07/09/2024

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	At 10:36 a.m., Room 313 had 2 towels on the floor, to the left of the bathroom door. An out of order sign was posted on the bathroom door. There was a strong urine odor in the bathroom and the floor had a puddle of water next to the toilet. A brown substance was observed on the toilet seat and on the floor, to the left of the toilet. The piping from the back of the toilet had been removed and was lying on the the bathroom floor. The trash can by bed 2 was observed out of reach and without a trash bag. There was an empty chocolate milk container, 2 straws, 2 plastic lids, unopened jelly and a snack wrapper next to the bed on the floor. On 6/8/24 at 10:41 a.m., RN (Register Nurse) 5 indicated a sewer pipe had collapsed and plumbers were in the building working on it last night and they were coming back today. She did not work yesterday and was unsure why the bathroom looked like it did. At 10:43 a.m., by Room 313, there was a large shop vac sitting next to the wall in the hallway. During an interview on 6/8/24 at 11:55 a.m., the Administrator indicated the contractors had left the shop vac in the hallway. At 10:44 a.m., a small puddle of water was observed on the left side of bed 2 with an empty plastic glass on the floor. On bed 2's bed side table, located at the end of the bed, sat a can of air freshener. During an interview on 6/8/24 at 10:55 a.m., the Central Supply Clerk indicated the can of air freshener spray should not have been in the resident's room as it was a chemical.		The facility would like to respectfully request a desk review. Brandon Jensen, LNHA STEP 1 Corrective action for the residents found to have been affected by the deficient practice: No resident was harmed by the alleged deficient practice. All environmental concerns were immediately addressed. STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice: All residents who reside at the facility could be affected by the alleged deficient practice. An audit of all resident areas was completed to ensure a sanitary environment any concerns were immediately addressed. STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur: The ED/Designee held an in-service for all direct care staff to provide education and expectations as it relates to infection control and sanitation practices including the prompt response to water/spills, proper disposal of trash, linen management, bedside commodes, maintenance equipment in halls, aerosol cans and general	

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	2. On 6/8/24, between 10:58 a.m. and 11:12 a.m., the following was observed on the 200 Hallway: At 11:00 a.m., bed linens were observed on the floor at the end of bed A in Room 215. The resident's bedside commode was next to the bathroom . The commode was observed with urine and toilet paper and a quarter of the way full. During an interview on 6/10/24 at 11:10 a.m., CNA (Certified Nursing Aide) 8 indicated it was not appropriate for soiled linens to be on the floor. Linens should be bagged and placed in the dirty linen container. Bedside commodes, she assumed, should be checked every 2 hours and emptied like a bed check. On 6/9/24 at 12:55 p.m., the Regional Director of Clinical Operations provided a current copy of the document titled "Infection Control Practices for Laundry/Linen" dated 10/29/13. It included, but was not limited to, "Policy...It is the policy of this facility to provide resident centered care...The safety of residents...will be primary consideration...." This Citation relates to Complaint IN00434995 3.1-19(a)(4) 3.1-19(f)(5) 3.1-19(g)(1)		sanitation in resident areas. STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur: The ED/Designee will audit all resident areas 5 days a week x 4 weeks, then 3 days a week for week x 4 weeks, then 1 day a week x 4 weeks for no less than 3 months and compliance is maintained to ensure proper sanitation practices are in place. The ED/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.	