PRINTED: 02/06/2024
FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155830		A. BU	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/22/2024		
	PROVIDER OR SUPPLIER			395 8T	ADDRESS, CITY, STATE, ZIP COD H AVENUE E HAUTE, IN 47804		
(X4) ID PREFIX TAG E 0000 Bldg	An Emergency Preconducted by the Irraccordance with 42 Survey Date: 01/22 Facility Number: Of Provider Number: AIM Number: 201 At this Emergency Harrison's Crossing compliance with En Requirements for North Participating Provided 483.73 The facility has a can had a census of 50 and a census of 50	2/24 013335 155830	E 00	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) The submission of this plan of correction does not indicate at admission by Harrison's Cross Health Campus that the findin and allegations contained here are accurate, true representat of the quality of care provided the living environment provide the residents of Harrison's Crossing Health Campus. Th facility recognizes its obligatio provide legally and medically necessary care and services to residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of facility. It is thus submitted as matter of statute only. The fac respectfully requests from the department a desk review for substantial compliance.	e in sing gs ein ion , and ed to e n to e its	(X5) COMPLETION DATE
K 0000							
Bldg. 01	Licensure Survey w		K 0	000	The submission of this plan of correction does not indicate at admission by Harrison's Cross Health Campus that the findin and allegations contained here are accurate, true representat of the quality of care provided the living environment provided	n sing gs ein ion , and	

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

Provider Number: 155830

TITLE (X6) DATE

the residents of Harrison's

Sean Medsker Executive Director 02/04/2024

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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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155830	(X2) MULTIPLE A. BUILDING B. WING	construction 01	COMI	E SURVEY PLETED 2/2024
	PROVIDER OR SUPPLIER		395 8	T ADDRESS, CITY, STATE, ZI TH AVENUE RE HAUTE, IN 47804	P COD	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TI DEFICIENCY	CORRECTION ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION
K 0355	AIM Number: 201 At this Life Safety Crossing Health Ca compliance with Romedicare, 42 CFR from Fire and the 2 Protection Associat Code (LSC), Chapt Occupancies and 4 This facility was lostory building deterconstruction and was facility has a fire alsomoke detectors in the corridors, and a first floor of the fact Lane-Assisted Living the lack of a 2 hour Lane-Assisted Living through 122 (11 beard from 122 (11 beard from 124 (11 beard from 125 (1	Code survey, Harrison's impus was found not in equirements for Participation in Subpart 483.90(a), Life Safety 012 edition of the National Fire ion (NFPA) 101, Life Safety er 19, Existing Health Care 10 IAC 16.2. Cated on the first floor of a two mined to be of Type V (111) as fully sprinklered. The arm system with hard wired the corridors, spaces open to II resident rooms. The entire iility, including the Legacy ing unit was surveyed due to fire-rated separation. Legacy ing unit includes rooms 113 dds). The facility has a capacity or including the Legacy ing unit, with 72 certified beds 250 at the time of this survey.	TAG	Crossing Health Car facility recognizes its provide legally and residents in an econ efficient manner. The hereby maintains it is substantial compliar state and federal recognory governing the mana facility. It is thus submatter of statute onl respectfully requests department a desk resubstantial compliar	mpus. The sobligation to medically services to its nomic and ne facility is in nee with all quirements gement of this bmitted as a y. The facility is from the review for	DATE
SS=D Bldg. 01	installed, inspecte	_				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER						COMPLETED	
155830		B. WING 01/22/2024					
NAME OF P	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	_		ADDRESS, CITY, STATE, ZIP COD		
			395 8TH AVENUE				
HARRIS	ON'S CROSSING H	IEALTH CAMPUS		IERRE	E HAUTE, IN 47804		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Portable Fire Extir	•					
	18.3.5.12, 19.3.5.		17.0	255	4 Compositive Action for the		02/02/2024
	Based on observation and interview, the facility failed to ensure 1 of 25 portable fire extinguishers		KU	355	1 Corrective Action for th	ie	02/02/2024
					resident(s) affected by the		
	were inspected at least monthly and the inspections were documented including the date				alleged deficient practice: No Residents, staff or visitors	woro	
	-	erson performing the			affected by the alleged deficie		
	_	dance with NFPA 10. LSC			practice.	116	
	-	ble fire extinguishers shall be			practice.		
	•	inspected and maintained in					
	accordance with NFPA 10. NFPA 10, the						
		le Fire Extinguishers, 2010			2 Corrective Actions tak	en	
	Edition, Section 7.2.1.2 states fire extinguishers				for those resident(s) having	the	
		ither manually or by means of			potential to be affected by the		
	an electronic monito	oring device/system at a			alleged deficient practice:		
		intervals. Where monthly					
	_	are conducted, the date the			No Residents, staff or visitors		
	_	was performed and the initials			were identified or reported any		
		rming the inspection shall be			findings suggestive of having		
		nanual inspections are			affected by the deficient practi	ce.	
		for manual inspections shall					
		label attached to the fire					
		inspection checklist			0 0000000000000000000000000000000000000		
	· ·	or by an electronic method.			3 Corrective Actions	_	
		pt to demonstrate that at least			including Measures/Systemi		
	_	inspections have been ficient practice could affect			changes put in place to assu		
	staff in the Elevator	-			the alleged deficient practice	;	
	starr in the Elevator	ivicciianicai iuuni.			does not re occur:		
	Findings include:				The Director of Plant Operation	ons	
	-				immediately removed the port		
	Based on observation	ons with the Senior Director of			fire extinguisher and performe	d the	
	Plant Operations an	d Executive Director during a			required inspection.		
	-	at 12:26 p.m. on 01/22/24, the					
		e tag for the ABC type portable					
	_	cated in the Elevator			Director of Plant Operations w		
		indicated annual maintenance			educated by Executive Director		
		sher was performed by the			K355 portable fire extinguishe	rs	
	_	st 2023 and had a monthly			NFPA 101. Portable fire		
	inspection for Septe	ember 2023. The fire			extinguishers are selected,		

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î ´		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155830			A. BUILDING <u>01</u> B. WING			COMPLETED 01/22/2024	
		100000	B. W1	_	_	01/22/	2024
NAME OF I	PROVIDER OR SUPPLIEF	1			ADDRESS, CITY, STATE, ZIP COD H AVENUE		
HARRIS	ON'S CROSSING H	IEALTH CAMPUS			HAUTE, IN 47804		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION monthly inspections for		TAG	installed, inspected, and		DATE
	1	and December 2023. Based on			maintained in accordance with	,	
	· · · · · · · · · · · · · · · · · · ·	e of the observation, the Senior			NFPA 10, Standard for portab		
	Director of Plant Op	perations agreed the			fire Extinguishers 18.3.5.12,		
	_	table fire extinguisher location			19.3.5.12, NFPA10.		
	_	y inspection documentation					
	for October, Novem	nber and December 2023.			4 0		
	This finding was re	viewed with the Executive			4 Corrective Actions that will be monitored to ensure t	-	
		nior Director of Plant			alleged will not re occur:	ile	
	Operations during t				anogou um notre cocur.		
					The Director of Plant Operation	ons	
	3.1-19(b)				and/or Designee developed a		
					weekly fire extinguisher inspec	ction	
					audit. The Director of Plant	eill	
					Operations and/or Designee w perform the observation audits		
					three times a week, for three	'	
					months. Findings will be review	wed	
					during the quarterly QA		
					Committee in order to determi	ne	
					the frequency for ongoing		
					monitoring. Findings suggestive		
					100% compliance may result i		
					cessation of the monitoring plant based on review.	111	
					basea cirroview.		
14 0000							
K 0920 SS=E	NFPA 101	ant Davis Oanda and					
Bldg. 01	Extens	ent - Power Cords and					
Diag. 01		ent - Power Cords and					
	Extension Cords						
	Power strips in a p	patient care vicinity are only					
	used for compone						
		ed electrical equipment					
	l '	les that have been					
	1	alified personnel and meet					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155830		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED B. WING 01/22/2024				LETED		
		ROVIDER OR SUPPLIER			395 8TH	ADDRESS, CITY, STATE, ZIP COD H AVENUE HAUTE, IN 47804		
	X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	TAG	the patient care vinon-PCREE (e.g., except in long-terr do not use PCREI meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care rother UL standard used with general cords are not used wiring of a structu temporarily are recompletion of the installed and mee 10.2.3.6 (NFPA 99 (NFPA 70), 590.3). Based on observation failed to ensure 3 or as a substitute for fielectrical wiring an accordance with NFC Code. NFPA 70, 20 requires that, unless cords and cables shifted for fixed wiring of a practice affects staff two smoke compart. Findings include: Based on observation of 1/22/24 between 1 following was discord and powered by room 208 b) a small christmass.	cinity may not be used for personal electronics), m care resident rooms that E. Power strips for PCREE r UL 60601-1. Power strips the patient care rooms of meet UL 1363. In cooms, power strips meet is. All power strips are precautions. Extension d as a substitute for fixed re. Extension cords used moved immediately upon purpose for which it was to the conditions of 10.2.4. 19), 10.2.4 (NFPA 99), 400-8 (D) (NFPA 70), TIA 12-5 on and interview, the facility for 3 flexible cords were not used equipment shall be in FPA 70, National Electrical conditions, Article 400.8 is specifically permitted, flexible all not be used as a substitute a structure. This deficient for and at least 20 residents in ments.	K 0	920	Corrective Action for the resident(s) affected by the alleged deficient practice: This deficient practice had the potential to affect one Resider room 208, 2 Residents in room 211 and one employee in the office. Corrective Actions take for those resident(s) having potential to be affected by the alleged deficient practice: No residents, staff or visitors identified or reported any finding suggestive of having been affet by the deficient practice.	en the ee were	02/02/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155830		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 01/22/2024	
	PROVIDER OR SUPPLIE		395 8T	ADDRESS, CITY, STATE, ZIP COD H AVENUE E HAUTE, IN 47804	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE
IAG	extension cord in rec) a refrigerator was a power strip in the Services office. The Operations removes observation. Based on interview observation, the Services confirm flexible cord being wiring.	esident room 211 as plugged into and powered by a Director of Environmental as Senior Director of Plant d the power strip upon at the time of each mior Director of Plant and each aforementioned used as a substiture for fixed eviewed with the Administrator	IAG	3 Corrective Actions including Measures/Systemichanges put in place to assist the alleged deficient practice does not re occur: The Director of Plant Operation immediately removed the extension cords from rooms 2 and 211 and removed the postrip from the Director of Environmental Services office. The Executive Director and/ordesignee provided re-education the Director of Plant Operation Electrical Equipment - Power Cords and Extension CFR(s): NFPA 101 Power strips in a patient care vicinity are only usefor components of movable patient-care-related electrical equipment (PCREE) assembly that have been assembled by qualified personnel and meet conditions of 10.2.3.6. Power strips in the patient care vicinismay not be used for non-PCR (e.g., personal electronics), except in long-term care resignous that do not use PCREE Power strips for PCREE meet 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside ovicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standard All power strips are used with general precautions. Extensions.	ic ure e e ons 208 wer e. or on to ns on sed les the let tut. E. tut. tut.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155830		A. BUILDING 01 CO		(X3) DATE SURVEY COMPLETED 01/22/2024	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD H AVENUE	
HARRISO	ON'S CROSSING H	EALTH CAMPUS		E HAUTE, IN 47804	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION	TAG	cords are not used as a substifor fixed wiring of a structure. Extension cords used tempora are removed immediately upo completion of the purpose for which it was installed and meet the conditions of 10.2.4.10.2.3 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3 4 Corrective Actions that will be monitored to ensure the alleged will not reform of Plant Operation and/or Designee developed a weekly audit that includes monitoring the usage of any postrips in employee offices as weas for the use of power cords Resident rooms on the Health Center. The Director of Plant Operations and/or Designee we perform the observation audits three times a week, for three months. Findings will be reviewed during the quarterly QA Committee in order to determine the frequency for ongoing monitoring. Findings suggesting 100% compliance may result in cessation of the monitoring platased on review.e in the DES office.	arily n ets 3.6 at the ons ower vell in vill s wed ne ve of in an

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155830	` ′	ILDING	ONSTRUCTION 01	(X3) DATE COMPL 01/22	ETED
NAME OF PROVIDER OR SUPPLIER HARRISON'S CROSSING HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP COD 395 8TH AVENUE TERRE HAUTE, IN 47804				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE

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