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	11/30/2021

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

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F 0000 Bldg. 00	This visit was for a COVID-19 Focused Infection Control Survey. Unrelated finding cited Survey date: November 30, 2021 Facility number: 010597 Provider number: 155657 AIM number: 200204440 Census Bed Type: SNF/NF: 85 Total: 85 Census Payor Type: Medicare: 11 Medicaid: 49 Other: 25 Total: 85 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on December 7, 2021.	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 complaint survey completed on 11/30/2021. Please accept this plan of correction as the provider's credible allegation of compliance. The facility would like to respectfully request a desk review. Jim Wesp, LNHA	
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental			

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

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	well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on record review and interview, the facility failed to ensure increased behaviors were documented, monitored, and addressed for 1 of 4 residents reviewed for behavioral health services. (Resident 3) Findings include: The clinical record for Resident 3 was reviewed on 11/30/21 at 10:30 a.m. Diagnoses included, but were not limited to, disorientation, altered mental status, major depressive disorder, severe with psychotic features, and schizoaffective disorder. The Admission MDS (minimum data set) assessment, dated 9/3/21, indicated the resident scored an 11 on her PHQ-9 (depression screening) questionnaire, which indicated mild depression. . The care plan, dated 9/9/21, indicated the resident used anti-depressant medication. Interventions included, but were not limited to, observe for side effects of antidepressant medications which included anxiety, hallucinations, insomnia, aggressive behavior, suicidal ideations, and a psych consult as needed. The care plan, dated 9/9/21, indicated the resident had a mood problem of altered sleep patterns, feeling down, depressed, and tired, with little energy, poor appetite, and trouble concentrating. Interventions included, but were not limited to, behavioral health consults as needed, communicate with resident and	F 0740	F740 Behavioral Health Services Corrective action for the residents found to have been affected by the deficient practice: Resident 3 continues to reside at the facility. Corrective action taken for those residents having the potential to be affected by the same deficient practice: All residents having an increase in behaviors have the potential to be affected by the deficient practice. A 30 day look back of behavior monitoring has been completed for documentation, monitoring, and the behavior being addressed. Any identified concerns were immediately addressed. Measures/systemic changes put into place to ensure the deficient practice does not recur: The Administrator/Director of Nursing/Designee held an in-service to provide education and expectations as it relates to the “Behavior Management” with respect to addressing, monitoring, and documentation related to residents with an increase in behaviors. Corrective actions to be monitored to ensure the deficient practice will not recur: The DON/Designee will audit residents with behaviors to ensure	12/31/2021

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	representative regarding mood state and treatment, encourage resident to express feelings, and notify medical provider of increased episodes of mood disturbance. The social services note, dated 11/2/21 at 3:43 p.m., indicated Social Services had spoken to the resident and she was crying and upset. The resident indicated she thought she was going to get kicked out of the facility soon. Social services would obtain a psychiatric consult and speak to nursing staff about a urinalysis. The social services note, dated 11/3/21 at 11:23 a.m., indicated Social Services had obtained a psychiatric consult for the resident. The Nurses note, dated 11/4/21 at 6:23 p.m., indicated the resident had a new order from the psychiatric Nurse Practitioner for Remeron 15 mg daily for depression. The nurse's note, dated 11/5/21 at 10:21 a.m., indicated the resident had new orders for a urinalysis for increased confusion. The lab/radiology results note, dated 11/7/21 at 8:15 a.m., indicated the physician was notified of the urinalysis results with no new orders given. The nurse's note, dated 11/9/21 at 12:43 p.m., indicated the resident's family member had called the facility stating his family member was acting very odd and asked if something was going on with the resident. The resident when spoken to, was laughing and then became very tearful. The physician was notified and gave orders for a urinalysis, a complete blood count, and a basic metabolic panel.		residents identified with an increase in behaviors have documentation, monitoring, and the behavior is addressed as follows: 5 residents per week for 4 weeks, then 3 residents per week for 4 weeks then 1 resident per week for 4 weeks and compliance is maintained. Any identified concerns will be immediately addressed. This will continue for no less than 3 months. The Director of Nursing/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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The nurse's lab/radiology results note, dated 11/12/21 at 10:14 a.m., indicated the physician was notified of the urinalysis results with no new orders given.

The behavior note, dated 11/12/21 at 11:30 p.m., indicated the resident came to the nurse's station "very upset". She would not stay in her room because she stated a black guy was stealing all of her stuff. The resident was asked what was missing and she indicated "my house." The staff member explained the person she spoke of had nothing to do with her house and he worked at the facility. She was not happy with that response and stated again she would not sleep in her room because he kept coming in there. The nurse took the resident to an empty room and offered to let her sleep there for the night and the resident agreed.

The behavior note, dated 11/12/21 at 11:34 p.m., indicated the CNA (Certified Nursing Aide) who the resident was talking about was instructed not to go into her room the rest of the night.

The clinical record lacked any further behavior notes, documentation of any further behaviors, or increased monitoring until 11/14/21.

The behavior monitoring flow sheets indicated the following:

- Day Shift: November 2 and 3, 2021 indicated the resident has two episodes of tearfulness. The only intervention listed was assess pain. The monitoring did not indicate any effectiveness of the interventions.

- Day Shift: November 1, 5, 6, 7, 8, 9, 10, 11, 12,

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	13, and 14 indicated no behaviors. - Evening Shift: November 2 and 3, 2021 indicated the resident has two episodes of tearfulness. The only intervention listed was assess pain. The monitoring did not indicate any effectiveness of the interventions. - Evening Shift: November 4 indicated "NA [not applicable]". - Evening Shift: November 5 indicated two episodes of tearfulness with interventions of assess pain, offer reassurance, and ensure safety. - Evening Shift: November 1, 6, 7, 8, 9, 10, 11, 12, 13, and 14 indicated no behaviors. - Night Shift indicated no behaviors for November 1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14, 2021. - Night Shift: November 4 indicated the resident had two episodes of behaviors however indicated "NA" as the behavior type and interventions. The MAR (medication administration record), dated November 4, indicated the resident had two episodes of behaviors, however, did not indicate the type of behavior or any interventions or effectiveness. The nurse's note, dated 11/14/21 at 10:55 p.m., indicated the nurse had walked in to administer the resident's medication at 8:45 p.m. and found the resident with a plastic bag over her head and a plastic bag tied around her neck. The nurse used scissors to cut the bag off her neck and removed the bag from her head. The resident started crying and stating no one liked her and she may			

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	as well die. She tried to talk to the resident and redirect her, but the resident was adamant no one liked her. She called for a CNA to come sit with the resident while she informed the DON and unit manager. The physician was notified and gave new orders to send the resident out to the emergency room. The undated, handwritten statement of CNA 4 indicated, on 11/13/21, the resident had been very upset and crying. She had made statements that people did not like her, and on Sunday night (11/14/21) the resident had packed up all of her belongings on her bed, which was normal for her, and she did it frequently. The handwritten statement of CNA 5, dated 11/16/21, indicated she had worked with the resident on Saturday and Sunday. She had spent Sunday lying in bed with all of her belongings packed. The typed statement of the AIT (Administrator in Training), dated 11/15/21, indicated she had spoken with the residents room mate who indicated the resident was acting "her normal self, which was 'all over the place.' She said she cries, laughs, packs things up, gets angry and then is very sweet ..." The undated handwritten statement of RN 6, indicated the resident over the past weeks had many different emotional episodes. Psychiatric services had been working with her and she had been started on an antidepressant recently. The clinical record lacked documentation of any behavior monitoring by nursing staff from the resident's readmission from the psychiatric hospital, on 11/22/21 to 11/30/21.			

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	During an interview, on 11/30/21 at 12:54 p.m., RN 5 indicated the resident would wake up crying, and she would just say nobody liked her and nobody waited on her. She would get in moods that no one liked her, it had been going on about a week prior to the incident. They probably did not document it all the time. There were behavior sheets for antidepressants on the MAR (Medication Administration Record). They were to document any behaviors of restlessness, sadness, and any side effects of antidepressants. During an interview, on 11/30/21 at 1:13 p.m., the Assisting DON (Director of Nursing) indicated if a resident was at a point where they needed every 30-minute checks they would need to be on one on one monitoring. The nurse who readmitted the resident was a new nurse and had been given instructions from Social Services to monitor the resident frequently. She would have to be educated on proper procedure for behavior monitoring. Education would consist of nursing documentation. The resident was supposed to have behavior monitoring orders in place. During an interview, on 11/30/21 at 1:05 p.m., the AIT (Administrator-in-training) indicated the resident should have had frequent checks in place. If the resident was having episodes of crying and packing up her belongings; she would have expected staff to notify the charge nurse, the nurse practitioner, and social services, and check with the physician to see if they needed to contact psychiatric services. The Behavior Management General policy, last revised 4/8/16, provided on 11/30/21 at 12:30 p.m. by the Assisting DON, included, but was not limited to, " ... 1. It is the policy of this facility to			

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	identify and safely manage residents who are exhibiting behaviors related to psychiatric diagnoses or who may present a danger to themselves or others. 2. Residents will be provided with a resident centered behavior management plan to safely manage the resident and others ... Procedure: 1. Assess for problematic/dangerous behaviors 2. Safety of the resident and others is a high priority. 3. Document the assessment of the behavior in the electronic medical records 4. Contact the physician for new onset or unusual behaviors ..." 3.1-37(a)			
F 0886 SS=E Bldg. 00	483.80 (h)(1)-(6) COVID-19 Testing-Residents & Staff §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19;			

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	(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state			

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	and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. Based on record review and interview, the facility failed to put a system in place to ensure unvaccinated employees were tested and results recorded. This deficient practice had the potential to affect 85 residents currently residing in the facility. Findings included: On 11/30/21 at 1:00 p.m., a review of the facility's list of staff members and their current vaccination status indicated there were 45 employees who were unvaccinated at this time. When asked for the testing records for those employees who were unvaccinated, the Infection Preventionist presented a copy of the facility's Healthcare Personnel COVID-19 Vaccination Cumulative Summary for Long Term Care Facilities dated 11/22, 11/24, 11/25, 11/26, and 11/29/21. Only certain names were highlighted, and no results were recorded. Review of these logs indicated the following: - On 11/22/21 - only 32 of the 45 unvaccinated employees were tested - On 11/24 through 11/26/2021 - only 25 of the 45 unvaccinated employees were tested - On 11/29/21 - only 30 of the 45 unvaccinated employees were tested During an interview with the Infection Preventionist on 11/30/21 at 2:43 p.m., she indicated that if the employees worked only	F 0886	F886 Testing-Residents and Staff Corrective action for the residents found to have been affected by the deficient practice: The deficient practice had the potential to affect 85 residents residing in the facility. Corrective action taken for those residents having the potential to be affected by the same deficient practice: The deficient practice had the potential to affect 85 residents residing in the facility. The system for ensuring unvaccinated employees were tested and results recorded has been reviewed and a new system immediately implemented to ensure the deficient practice was immediately corrected. Measures/systemic changes put into place to ensure the deficient practice does not recur: The Administrator/Director of Nursing/Designee held an in-service to provide education and expectations as it relates to the “COVID-19 Employee Testing, Quarantine, Return to Work and LOA (Leave of Absence)” with respect to the requirements for testing of unvaccinated employees, expectations of compliance with the testing policy, and follow up to the testing	12/31/2021

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	weekends, they were supposed to come in and be tested or test at their weekday job and bring in the results because she didn't work weekends. She was doing her best and that the staff were given sufficient time to come in and be tested, but if they weren't highlighted on the list, then they were not tested. She couldn't say as to why some of them weren't coming into the facility as required and that probably was a flaw of hers and she couldn't speak to that unfortunately. Staff normally just came into her office and the facility tested them. She would go through and highlighted her line list as to who was being tested. She did not cross-reference the schedule to see that the staff not highlighted were tested before working. On 11/30/21 at 10:30 a.m., the Administrator-in-training presented a copy of the facility's current policy titled COVID-19 Employee Testing, Quarantine, Return to Work and LOA (Leave of Absence). Review of this policy included, but was not limited to, "Policy: CommuniCare seeks to foster a safe and healthy environment for all our employees and residents. As a result, CommuniCare is requiring COVID-19 testing for all Facility Staff as needed and as otherwise required by law...COVID-19 Employee testing:..All CommuniCare employees will be tested in accordance with this policy as required by local, state and federal, and if otherwise deemed necessary by the facility in the event of a COVID -19 outbreak or employee exposure to COVID-19..." 3.1-18(b)		process if compliance is not met. Corrective actions to be monitored to ensure the deficient practice will not recur: The DON/Designee will audit unvaccinated employees testing compliance as follows: 5 staff per week for 4 weeks, then 3 staff per week for 4 weeks then 1 staff per week for 4 weeks and compliance is maintained. Any identified concerns will be immediately addressed. This will continue for no less than 3 months. The Director of Nursing/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.	