STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. Building B. Wing	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harrison Healthcare Center	150 Beechmont Dr Corydon, IN 47112

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 34231 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 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. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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 blood pressure was 107. On 6/5/24 at 4:00 p.m., the resident's systolic blood pressure was 106. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 3.1-37

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 34231 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. 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. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34231 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 [ROOM NUMBER], there were 2 towels and a bath blanket on the floor under the heating and air unit in room [ROOM NUMBER]. 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. At 10:36 a.m., room [ROOM NUMBER] 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 [ROOM NUMBER], 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. 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 [ROOM NUMBER]. 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. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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)