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	01/29/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview and record review, the facility failed to ensure a resident with a history of Urinary Tract Infections (UTIs) was provided proper management of the urinary catheter drainage system by maintaining the drainage system off the floor for 2 of 5 residents reviewed for bowel and bladder. (Residents 71 and 86)Findings include:1. During an observation, on 1/22/26 at 9:30 a.m., Resident 71's urinary catheter bag was resting on the floor next to the resident's left side of the recliner. During an observation and interview, on 1/22/26 at 12:17 p.m. Resident 71's urinary catheter bag was on the floor next to the resident's right side of the recliner. The Director of Nursing (DON) was present in the room and indicated the resident moved the catheter bag on his own. The record for Resident 71 was reviewed on 1/26/26 at 8:15 a.m. The diagnoses included, but were not limited to, retention of the urine, benign prostatic hyperplasia (BPH) (enlargement of the prostate gland), with lower urinary tract symptoms, obstructive and reflux uropathy (blockage of the urinary tract and backward flow of urine), and hematuria (blood in urine). The Comprehensive Minimum Data Set (MDS) assessment, dated 1/15/26, indicated the resident was severely cognitively impaired. The care plan, dated 11/24/25 and revised 1/22/26, indicated the resident had an indwelling urinary catheter related to obstructive and reflux uropathy, BPH, urinary retention, and hematuria. Dated 1/22/26, the resident moved the catheter bag at times due to being fidgety. The interventions, dated 11/17/25, staff were to ensure the securement device was in place. The resident's care plan lacked interventions related to the resident moving the catheter bag onto the floor. The physician's order, dated 11/25/25, indicated to secure the indwelling catheter tubing using anchoring device to prevent movement and urethral traction. The nurse's note, dated 12/17/25 at 1:45 p.m., indicated the NP reviewed the 12/4/25 urinalysis. A new order was received for Bactrim. The nurse's note, dated 12/17/25 at 5:19 p.m., indicated the resident's catheter bag had blood in the urine. The resident had blood off and on in the urine since admission. The NP was aware. 2. During an observation on 1/22/26 at 9:40 a.m., the bottom of the Resident 86's urinary catheter bag was resting on the floor. During an observation on 1/23/26 at 9:15 a.m., the bottom of the catheter sitting on the floor attached to the bed rail. The record for Resident 86 was reviewed on 1/26/26 at 9:15 a.m. The diagnoses included, but were not limited to, neuromuscular dysfunction of the bladder (nerve damage which disrupts brain-bladder communication), and chronic kidney disease (progressive and long-term condition where kidneys become damaged and lose ability to filter waste). The nurse's note, dated 7/3/25 at 9:30 a.m., indicated the resident's urinary catheter was found lying beside the resident in her bed. The resident did not know what happened. The urinary catheter was replaced without difficulty. There was clear yellow urine in the bedside drainage bag. The nurse's note, dated 7/24/25 at 12:33 a.m., indicated the resident's urinary catheter had come out and the resident was unsure how it happened. A new 18 French urinary catheter was placed without difficulty. Cloudy dark yellow urine was observed without odor. The nurse's note, dated 11/7/25 at 11:45 p.m., indicated the resident was treated at a local hospital for an admitting diagnosis of a UTI. The physician's order, dated 1/14/26, indicated to monitor the urinary catheter to ensure a privacy bag and catheter leg strap were in place at all times. The physician's order, dated 1/14/26, indicated to secure the urinary catheter tubing and was (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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	01/29/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	anchored to prevent movement and urethral traction. The resident's clinical record lacked documentation of a care plan for the indwelling urinary catheter. During an interview, on 1/29/26 at 11:33 a.m., the DON indicated if staff saw the urinary catheter bag on the floor, staff should have placed the catheter bag in a washbasin or had a barrier to prevent infection from bacteria. The current Catheter Drainage Bag and Tube Maintenance policy, included, but was not limited to, . i. Drainage bags will not be placed on the floor . 3.1-41(a)(2)

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	01/29/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and interview, the facility failed to ensure a staff member followed the policy and procedure when administering narcotics for 1 of 4 residents reviewed for pharmaceutical services. (Resident B). Findings include:The clinical record for Resident B was reviewed on 1/28/26 at 11:00 a.m. The resident's diagnoses included, but were not limited to, rheumatoid arthritis with rheumatoid factor (an autoantibody found in patients with rheumatoid arthritis often signaling a more sever, aggressive, and erosive form of the disease), spinal stenosis (narrowing of the spinal canal causing increased pressure on the spinal cord and nerves), and primary osteoarthritis (degenerative joint disease characterized by the progressive breakdown of articular cartilage).A facility document, titled Individual Resident's Controlled Substance Administration Record, dated 10/10/25, indicated the form was for Resident E (a family member) of Resident B. The Morphine Sulfate (Concentrate) Oral Solution 100 milligrams (mg)/5 milliliter (ml) was signed out on the narcotic sheet on the following date and times with a handwritten note on this record that indicated Given to Resident B.-10/17/25 at 2:00 p.m.-10/17/25 at 5:30 p.m.The care plan, dated 10/17/25, indicated the resident was on hospice service. The interventions, dated 10/17/25, included, but were not limited to, administer medications according to the medical provider's orders and report abnormal findings to medical provider, resident representative, and hospice company; offer emotional support to the resident regarding choices with treatment; and administer non-pharmacological interventions and evaluate the effectiveness of interventions.A physician's order, dated 10/17/26, indicated the resident could have Morphine Sulfate (Concentrate) Oral Solution 100 milligrams (mg)/5 milliliter (ml). The resident was to receive 0.25 ml by mouth every hour as needed.The record lacked documentation of the family being notified that Resident B was given Resident E's Morphine until his medication supply arrived.During an interview, on 1/23/26 at 9:30 a.m., Registered Nurse (RN) 8 indicated that Resident B's family member had already been signed up for hospice with her medications brought in from home. Resident B signed up for hospice on 10/17/25 and needed pain medication. His medication had not arrived at the facility. RN 8 called the family member of both residents to get permission to give Resident E's medication to Resident B. The family member agreed and the medication was given to Resident B. RN 8 called the Director of Nursing (DON) to make her aware of his actions.During an interview, on 1/28/26 at 11:50 p.m., Licensed Practical Nurse (LPN) 9 indicated that if she needed liquid oral Morphine for a resident with a new physician order. A code would be requested through the Emergency Drug Kit (EDK), and the pharmacy will then text a code to obtain the medication. The LPN indicated that being a hospice patient did not affect how a new medication was obtained and should always be taken out of the EDK if it has not arrived at the facility.During an interview, on 1/29/26 at 11:25 a.m., the DON indicated that Resident B did not run out of Morphine, but that the Morphine was a new order on 10/17/25 due to the resident being newly enrolled in a hospice company. RN 8 was on duty and had called the family for permission to use the bottle of morphine brought from home for Resident E. The family member wanted Resident B to have a dose of Morphine from Resident E's bottle. The RN gave the medication without contacting leadership.A current facility policy, titled Medication Administration, dated 2013, and provided by the Executive Director on 1/29/26 at 1:00 p.m. The policy indicated, .Policy: The purpose of this policy is to provide guidance for general medication administration.1. f Observe the five rights in giving medication. I. the right resident.1. y Do not share or borrow medications from others. This citation relates to Intake 2648076 3.1-25 (a)3.1-25 (b)(1)3.1-25 (c)