STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155830	A. Building B. Wing	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harrison's Crossing Health Campus	395 8th Avenue Terre Haute, IN 47804

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview, the facility failed to ensure documented physician rationale for a declination of pharmacy recommendations and failed to ensure the physician signed and dated the pharmacy recommendations for 3 of 5 residents reviewed for unnecessary medication (Residents 19, 56, and 8). Findings include: 1. Resident 19's record was reviewed on 4/15/26 at 2:13 p.m. The profile indicated that the resident's diagnoses included, but were not limited to, unspecified dementia (a clinical term for cognitive decline that prevents a definitive diagnosis of a specific type), unspecified severity with anxiety (a diagnosis for significant anxiety, panic, or fear that causes distress or functional impairment but does not fully meet the specific criteria for other, more defined anxiety disorders), and depression unspecified (a diagnosis used when symptoms of depression cause significant distress or impairment but do not meet the full criteria for a specific depressive disorder). An annual Minimum Data Set (MDS) assessment, dated 3/20/26, indicated the resident had severe cognitive impairment and was on an anti-psychotic medication. A pharmacy recommendation, dated 11/25/25, recommended a reduction of aripiprazole (anti-psychotic medication) 5 milligrams (mg) daily. There should be documentation related to clinically contraindicating a gradual dose reduction including specific and individualized rationale for why the medication was medically necessary at the current dose. The pharmacy recommendation was marked as denied and the form lacked a documented rationale as to why the physician denied the recommendation. The electronic health record lacked documentation of a physician rationale for a declination of the pharmacy recommendation. During an interview, on 4/17/26 at 2:30 p.m., the Regional Clinical Support Nurse indicated she was unable to provide a documented rationale from the physician for his denial of the gradual dose reduction of the aripiprazole medication. She further acknowledged the physician should have documented a rationale for declination of the pharmacy recommendation. 2. Resident 56's record was reviewed on 4/15/26 at 10:40 a.m. The profile indicated the resident's diagnoses included, but were not limited to, insomnia unspecified (a general diagnosis for consistent difficulty falling asleep, staying asleep, or getting quality sleep that causes daytime impairment, but lacks a specific, clearly defined underlying cause) and Alzheimer's disease unspecified (a medical diagnosis for progressive brain decline that causes dementia, applied when the specific stage or age of onset has not been documented). A quarterly Minimum Data Set (MDS) assessment, dated 3/14/26, indicated the resident had severe cognitive deficit. (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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order, dated 3/10/25, indicated to administer two 25 milligram (mg) tablets (50 mg) of trazodone (medication to treat insomnia), at bedtime. A pharmacy recommendation, dated 9/15/25, indicated the resident's trazodone order had been in place since, March 2025 and recommended to consider changing the dose to 25 mg at bedtime as needed (PRN) times 14 days and re-evaluate the need for the medication. The physician declined the recommendation. The recommendation form lacked documentation of the justification for the physician declination. On 4/16/26 at 9:10 a.m., the Regional Clinical Support provided a document titled, Psychiatry Progress Note, with a date of service on, 9/22/25. The document lacked documentation that the resident had indicated he was not sleeping well. The document indicated, .He believed that he eats and sleeps well. He denied any current concerns at this point in time. On 4/16/26 at 9:10 a.m., the Regional Clinical Support provided a document titled, BH Progress Note, with a date of service on 9/26/25. The document lacked documentation that the resident had indicated he was not sleeping well. The document indicated, .Resident denies issues with sleeping at this time. Consulted with staff whom reported the resident is stable and functioning at baseline. During an interview, on 4/16/26 at 9:10 a.m., the Regional Clinical Support indicated the expectation was that the physician or nurse practitioner would provide documented justification for any declinations of pharmacy recommendations. 3. Resident 8's record was reviewed on 4/15/26 at 2:24 p.m. The profile indicated the resident's diagnoses included, but were not limited to, unspecified dementia with psychotic disturbance (a diagnosis for a person with significant memory loss and cognitive decline that is accompanied by hallucinations [seeing, hearing, smelling, tasting, or feeling things that are not actually there, yet feel completely real] or delusions [a firm, fixed belief that is clearly false, irrational, or not based on reality, which a person holds onto despite overwhelming evidence to the contrary], where the exact cause is not yet determined). An annual Minimum Data Set (MDS) assessment, dated 4/3/26, indicated the resident had severe cognitive deficit and received antipsychotic (medications to treat psychosis, such as hallucinations or delusions) and antianxiety medication. A physician's order, dated 10/24/24, indicated to administer 0.25 milligrams (mg) of alprazolam (antianxiety medication) three times a day. A historical review of the resident's medication regimen indicated that the resident had received 100 mg quetiapine (antipsychotic medication) twice daily, since April 2025. A physician's order, dated 2/12/26, indicated to administer 50 mg of quetiapine one time a day. A physician's order, dated 2/12/26, indicated to administer 100 mg of quetiapine at bedtime. A pharmacy recommendation, dated 7/17/25, indicated to consider a dose reduction of quetiapine 100 mg twice daily to 50 mg every morning and 100 mg at bedtime. The physician declined the recommendation and document that the resident was on hospice (end of life care) services. The form lacked any further justification for the physician's decision to decline the recommendation. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additionally, the form lacked documentation of the physician's signature and date. A pharmacy recommendation, dated 9/15/25, indicated to consider a dose reduction of the resident's Xanax (alprazolam) 0.25 mg three times daily to 0.25 mg two times daily. The physician declined the recommendation. The form lacked documentation of the physician's signature and date. Review of behavior tracking reports from September 2025 and forward, indicated the resident had experienced anxiety related behaviors. During an interview, on 4/16/26 at 9:10 a.m., the Regional Clinical Support indicated the expectation was that the physician or nurse practitioner would provide documented justification for any declinations of pharmacy recommendations and sign and date the document when it was completed. On 4/16/26 at 9:10 a.m., the Regional Clinical Support provided a document, with a revision date of January 2018, titled, Consultant Pharmacist Reports, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedures.E. Recommendations are acted upon and documented by the facility personnel and/or prescriber. 1) Prescriber accepts and acts upon suggestion or rejects and provides an explanation for disagreeing. 410 IAC (Indiana Administrative Code) 16.2-3.1-3(w)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assess or provide valid medical justification from the attending physician to determine if continued use or removal of a urinary catheter was clinically warranted for 1 of 1 residents reviewed for catheter use (Resident 41).Findings include:On 4/14/26 at 1:41 p.m., during an interview, Resident 41's husband indicated the resident had an indwelling foley catheter (a thin, flexible catheter used especially to drain urine from the bladder). He indicated the catheter was placed in the hospital and she had no issues with urination prior to being in the hospital and did not know why she still had a catheter. He had requested it be removed. The husband indicated he had not been informed of the reason for the catheter.On 4/15/26 at 11:00 a.m., the medical record of Resident 41 was reviewed. The resident was admitted to the facility on [DATE]. Diagnosis included, but were not limited to, surgical aftercare following surgery on the nervous system clot evacuation (removal of blood clot in the brain), hemiplegia (a loss of strength in the arm, leg, and sometimes face on one side of the body) and hemiparesis (a relatively mild loss of strength) following nontraumatic intracerebral hemorrhage (bleeding in the brain), neuromuscular dysfunction of bladder, unspecified (a condition where a person loses bladder control due to nerve damage or diseases of the nervous system).A physician order, dated 11/19/25, indicated use of an Indwelling Urinary Catheter, Medical reason: neurogenic bladder (a dysfunction of the bladder caused by damage to the nerves that control urination).A care plan, dated 11/19/25, indicated resident used a foley catheter. Interventions included, but were not limited to, provide assistance with catheter care and change foley catheter per physician orders. Review of the hospital discharge and discharge summary records from admission to the facility on [DATE] lacked a diagnosis of neurogenic bladder. The records indicated the catheter was placed due to an unstageable wound (a wound where the base is completely covered by dead tissue). The wound was on the coccyx (a small, triangular area located at the very bottom of the spinal column).Resident 41's current medical record lacked clarification or justification by the physician for foley catheter use.A quarterly Minimum Data Set (MDS) assessment, dated 2/26/26, indicated the resident was cognitively impaired and had an indwelling foley catheter during the assessment period.On 4/17/26 at 10:30 a.m., during an interview the resident indicated she could not remember if she had any issues with urinating prior to hospitalization but since then she had some confusion. She indicated she could not remember if the staff had discussed the catheter with her.On 4/17/26 at 11:00 a.m., during an interview the Regional Nurse Consultant indicated the justification for the foley catheter was because the resident has a wound on her bottom and if the catheter was removed the wound would be contaminated creating an increased risk of infection. She acknowledged the facility did not have an assessment from the physician indicating the clinical reason for maintaining an indwelling catheter.On 4/17/26 at 1:26 p.m., the Director of Nursing provided a document, titled, Guidelines for the use of Indwelling Catheter, dated 5/11/16, and indicated it was the policy currently being used by the facility. The policy indicated, .An indwelling catheter is not used unless there is a valid medical justification.1.Urinary catheters are deemed medically necessary for the following reasons and must have a supporting diagnosis for its use).other conditions as deemed valid by the attending physician and or urologist with supporting documentation.2. Resident/Representative has the right to decline the use of an indwelling catheter. If resident/representative declines, information and education should be provided indicating the risks and benefits. 3. Resident/Representative should be informed of the risks and the benefits of indwelling catheter use.410 Indiana Administrative Code (IAC) 3.1 3.1-41(a)(2)