STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155852	A. Building B. Wing	11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harrison Springs Health Campus	871 Pacer Drive NW Corydon, IN 47112

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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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. Based on record review and interview, the facility failed to ensure staff were available for one to one supervision related to residents with behaviors requiring one to one supervision for 3 of 4 residents reviewed for sufficient staff for behavior Health Needs. (Residents B, C, and D)Findings Include:1.The record for Resident B was reviewed on 11/6/25 at 10:00 a.m. The diagnoses included, but were not limited to, wedge compression fracture of the first lumbar vertebra, urinary tract infection altered mental status, and dementia. The Minimum Data Set (MDS) assessment, dated 9/9/25, indicated the resident was moderately cognitively intact. The physician order indicated the following: - Buspirone 30 (mg) milligram tablet, given twice a day related to anxiety. The start date was 9/5/25 - Risperidone 0.5 mg tablet once a day related to psychosis. The start date was 9/5/25. - Venlafaxine 150 mg capsule extended release at bedtime related to depression. The start date was 9/5/25. - Effexor XR (venlafaxine) 75 mg capsule, extended release once a day. The start date was 9/8/25. - Risperdal (risperidone) 0.5 mg tablet at bedtime related to psychosis. The start date was 9/13/25. The care plan, dated 9/14/25 and revised on 9/17/ 25, indicated Resident B demonstrated exit-seeking behaviors. The interventions included, but were not limited to, monitor for wandering triggers, encourage regular family contact and visits with others, evaluate the need for a secure unit and transfer the resident if needed, apply a wander guard monitor as ordered, offer diversional activities as needed, re-direct the resident away from doors and exits as needed, a family member present with the resident and an outside agency sitter present with the resident when the family member was not at the bedside. The nurse's note, dated 9/12/25 at 9:26 a.m., indicated the resident was in her room and assistance was provided with her morning routine. Resident B indicated she needed to go out the exit door beside her room because she had to go to town. (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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Social Service Director (SSD) note, dated 9/12/25 at 11:00 a.m., indicated the resident was observed walking in the hallway by the therapy gym headed towards hallway exit door. Resident B was walking without her assistive device or her back brace. When asked where she was going, she indicated to office one eleven. The resident was assisted to a chair in the hallway, and a wheelchair was obtained, and the resident was taken to her room with one-on-one supervision. The resident's family member was notified and requested to sit with the resident due to her exit seeking behaviors. The family member indicated he would get to the facility as soon as he could; however, he had an appointment and did not know what time he would be at the facility. Verbal consent was obtained from the family member for a wander guard to be applied related to the resident's exit seeking behaviors. The family member was notified that if the family was unable to provide the resident with supervision related to exit seeking behavior, then the facility may need to find alternate placement for resident related to her safety. The SSD note, dated 9/12/25 at 6:12 p.m., indicated the resident was exit seeking. The family member was asked to stay or to ensure 24-hour care for the resident. The family member signed a contract with an outside private agency to provide 24-hour care. The SSD faxed the contract to the outside agency, and they confirmed the above service agreement. The family member indicated he understood he had to stay with the resident until the outside agency arrived. The IDT note, dated 9/14/25 at 8:40 a.m., indicated the resident was observed with exit seeking behaviors, increased confusion and anxiety, and ambulating without assistance in the hallways without her back brace on. Her mood remained pleasant but only oriented to herself. The resident indicated she had to leave to go to town and she had to get to her husband's office. A wander guard was placed for the resident's safety. She was being treated for a urinary tract infection (UTI). The resident's family member was called, and he came to the facility to see the resident. The family member indicated he was unable to stay with the resident. The SSD spoke with the family member and arrangements were made for a sitter to stay with the resident. The nurse's note, dated 9/15/25 at 5:52 a.m., indicated the resident had periods of increased confusion. The sitter was at the resident's bedside. The Director of Nursing (DON) note, dated 9/16/25 at 12:31 p.m., indicated the resident was observed to be up wandering on the hallway with no assistance and had removed her wander guard. The wander guard was replaced. The resident's family member was notified of the resident requiring one on one supervision for her safety. The family was at the facility sitting with the resident. The SSD followed and assisted with deciding to transfer the resident to an appropriate facility and assisted the family member with arranging a sitter. 2. The record for Resident C was reviewed on 11/6/25 at 10:45 a.m. The diagnoses included, but were not limited to, diverticulitis of large intestine with perforation and abscess without bleeding, immunodeficiency, panlobular emphysema, atherosclerotic heart disease of the native coronary artery with angina pectoris, spondylosis of the lumbar region, tobacco use, depression, psoriasis, severe protein-calorie malnutrition, anxiety disorder, and hypertension. The nurse's note, dated 10/3/25 at 12:52 p.m., indicated the nurse spoke to the resident's family regarding psychotropic medications and narcotics. The family member indicated they did not want the resident to utilize narcotics while at the facility because they caused the resident to have hallucinations and delusions and did not help the resident. The nurse practitioner was notified (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The nurse's note, dated 10/3/25 at 4:49 p.m., indicated the resident was observed in his bathroom toileting himself. The resident was walking with his pants around his ankles. The nurse assisted the resident with his toileting needs. Upon entering the restroom, the resident was anxious and agitated. The resident began raising his voice toward staff and cursing them. The resident voiced a desire to exit seek. The resident indicated, I am getting out of here. I am going home. I am going to go right out that front door. The resident was offered activities but refused at this time. The resident was provided with one-on-one supervision. A call was placed to the resident's family to inform them of the resident needing a sitter for resident safety. The resident's family was notified of the need for a wanderguard and the wanderguard would need to be placed on the resident for his safety. Verbal consent was obtained from the resident's family, for the wanderguard to be applied. The resident's family member indicated they were on their way to the facility; however, could not provide one-on-one care due to leaving for a trip tomorrow. The resident's family member was informed that a sitter could be hired by the family to sit with the resident, the resident could be sent to the hospital of their choice for evaluation, or an alternate facility placement could be attempted for his safety. The family member wanted to speak with the resident upon arrival at the facility. Upon the attempt to place a wanderguard, the resident refused for the wanderguard to be placed. The Executive Director (ED) and the nurse discussed with the resident the need for the wanderguard to be placed for safety. The resident continued to refuse the wanderguard. The resident continued to exhibit verbal and physical aggression toward staff. The resident had behaviors of throwing objects in his room and cursing toward staff. The resident explained to the staff that he had required hospitalization in the past related to behavioral issues. The resident continued to voice exiting seeking behaviors. The resident indicated a need to have a cigarette at this time. Staff explained to the resident that the facility was a non-smoking facility. The resident's family member arrived at this time and his behavior was explained. One-on-one care was provided by the family member at this time and the Nurse Practitioner (NP) was notified. The nurse's note, dated 10/3/25 at 5:16 p.m., the family member indicated to the staff the resident would not exhibit behaviors going forward and would not continue to exit seek. The nurse indicated to the family member the resident was in need of a secure facility related to his exit seeking behaviors as the facility was not equipped for one-on-one care of a skilled secure unit. The nurse indicated to the family member that it was unknown when the exit seeking behaviors and verbal and physical aggression behaviors would occur and the resident needed a sitter to provide one-on-one care when his behaviors occurred as the facility did not provide one-on-one care. The nurse informed the family member that a sitter could be hired to sit with the resident. The family member indicated that there was family that could come to the facility to sit with the resident if needed or that a sitter could be hired. The family would provide 24-hour supervision to the resident for his safety. The family member was informed that staff would attempt to find alternate facility placement. The nurse's note, dated 10/3/25 at 5:31 p.m., indicated staff placed calls to several facilities. Some facilities requested resident documents to be faxed to their facilities. Resident insurance required precertification for rehabilitation facilities and would not be able to accept the resident on this day. Voice messages were left at other facilities. The family member was notified. The family member voiced concerns with cancelling a scheduled vacation. The family member was informed that the resident would need 24-hour supervision related to his exit seeking behaviors. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The nurse's note, dated 10/3/25 at 6:50 p.m., indicated the resident's family member asked staff if alternate facility placement had been arranged for the resident. The family member was informed that documents had been faxed, but the resident had not been accepted to another facility at this time and that with the resident's insurance, he would require a precertification to be admitted to a different rehabilitation facility. The family member indicated she pushed her vacation back and would provide one-on-one care for the resident through the weekend. The nurse's note, dated 10/3/25 at 7:40 p.m., indicated the resident's family member inquired with the nursing staff what companies provided sitting services that could be hired to sit with resident. The family member was informed that staff would call and obtain sitter prices and services. The family member requested to self-call the services and was provided with names of the companies. The family member indicated they were going to call to obtain pricing in case they would need to hire a sitter for the resident. The family member indicated to staff, they were staying with the resident to provide him with 24-hour supervision. The nurse's note, dated 10/3/24 at 7:54 p.m., indicated staff attempted to apply the wanderguard to the resident. Consent was obtained from the resident's family member to apply the wanderguard. The wanderguard was applied to the resident's left wrist. The family member was contacted if staff could call facilities that provided sitting services for the family. The family member indicated they did not want staff to call the services, that she had already called the services and did not want to use them. The staff reiterated to the family member that the resident needed 24-hour supervision at this time related to his exit seeking behavior. The family member indicated they understood and would be at the facility to stay with the resident. The resident was currently resting in bed with no behaviors. The DON, ED, NP, and nursing staff were notified. The nurse's note, dated 10/4/25 at 4:09 a.m., indicated the resident was resting abed with his eyes closed at this time. The resident had slept well this shift with minimal behaviors. The resident had personal items packed to go home, but the resident was easily redirected, with no outbursts. His family member was at his bedside and the wanderguard was in place. The nurse's note, dated 10/4/25 at 4:12 a.m., the resident's family member indicated they were going to be staying with the resident 24/7 at this time, but verbalized they had a flight on Monday. The family member indicated on the phone earlier that they might not stay all weekend and had things to do. The family member had stayed with the resident this shift without incident. The nurse's note, dated 10/4/25 at 9:55 a.m., indicated the family member remained one-on-one with the resident. The resident's eyes were closed with no exit seeking, agitation, anxiety, or behaviors during this shift. The nurse's note, dated 10/4/25 at 12:05 p.m., indicated the resident's family member requested to speak with the ED regarding plans for the resident. The family member was told that the ED was out of town. The family member then requested to speak to the DON. Information was provided to the DON, and the family member was called by the DON. The DON indicated that 24/7 supervision would need to remain in the meantime, but for short periods at a time, the family member could leave as long as someone came back. The family member indicated to the nurse she needed to go home and shower in a couple of hours and pack for her vacation and then attend mass on Sunday morning. The nurse indicated she could provide the one on one care for those times, but the family member would have to return. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The nurse's note, dated 10/4/25 at 2:59 p.m., indicated the family member left to go home and shower and obtain more clothes. The nursing staff provided one-on-one care at this time. The resident was toileted and was in bed at this time resting. The family member indicated they would be back before 6:00 p.m. The family member also indicated they had been talking to a local nursing facility regarding moving the resident. The nurse's note, dated 10/4/25 at 5:10 p.m., indicated the resident remained one on one with staff at this time. The resident had no behaviors during this shift. The resident was in the dining room eating dinner and socializing with peers at this time. He was pleasant and cooperative with all care today. The nurse's note, dated 10/5/25 at 3:50 p.m., indicated the resident had no behaviors this shift. No exit seeking, no agitation, and no anxiety. He was pleasant and cooperative with all care. The resident ate his meals in the dining room and socialized with his peers. The family member and/or staff had remained one on one all day. The resident was encouraged to attend activities. The admission MDS assessment, dated 10/6/25, indicated the resident was moderately cognitively impaired. The Interdisciplinary Team (IDT) note, dated 10/6/25 at 5:37 a.m., indicated in attendance were the DON and Assistant Director of Nursing (ADON). The resident had agitation when he was told he could not leave the facility alone and go home. The resident began to exhibit verbal and physical aggression and throwing objects in his room and cursing toward staff. The resident indicated to the ADON he had required hospitalization in the past related to behavioral issues. The resident continued to voice exit seeking behaviors. Staff attempted to place a wanderguard and the resident initially refused to let staff place it. The family member was called and then came to the facility. The family member indicated the resident was acting out because of frustrations he had towards the family member. The family member indicated to staff of the initial plans to fly out of town on Saturday. The ED and ADON spoke with the family member and made them aware that for resident safety, family would need to provide one-on-one care with the resident whether that be by a hired service, family, or themself. The resident eventually allowed staff to provide the wanderguard. Alternate placement could not be found for a secure unit facility before the weekend, so the resident continued with one-on-one supervision. The admissions team and family member were to resume finding alternate placement. The resident did not have any further behaviors once the family member arrived. The resident did admit to the facility with an order for as needed (prn) Ativan, but the family member indicated this medication caused the resident to have hallucinations and family asked to have it discontinued. The care plan, dated 10/6/25 and last revised 10/14/25, indicated the resident demonstrated exit-seeking behaviors. The interventions, dated 10/6/25, included, but were not limited to, apply a wanderguard to the left wrist and monitor as ordered, evaluate the resident's need for a secured unit and transfer if needed, monitor for wandering triggers such as a need for toileting, inactivity, time of the day, et cetera (etc)., offer diversional activities as needed, encourage regular family contact and/or visits with others, provide a structured routine to the resident's day, and redirect the resident away from the doors and exits as needed. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The nurse's note, dated 10/6/25 at 3:07 p.m., indicated a call was received for the family member indicating they would be unable to provide 24-hour supervision for the resident. The family member indicated their spouse would be in the facility to sit with the resident tonight, but the family member would be unable to provide supervision 24-hours. The family member indicated, I'm getting on a plane and I can't work it out. The nurse's note, dated 10/6/25 at 5:41 p.m., indicated the family member inquired as to whether the resident actually needed 24-hour supervision. The family member was informed that the resident needed one-on-one supervision at this time related to the resident previously voicing a desire to exit seek and due to the facility not being equipped to provide one-on-one care. The resident's family member indicated they did not see the point in sitting with the resident all day but would continue to provide one-on-one care for resident. The nurse's note, dated 10/17/25 at 11:38 a.m., indicated the resident discharged home with his family member. The discharge paperwork was reviewed with the resident and family. Colostomy education was provided, and the resident was able to show the nurse how to change the bag. All supplies were sent with the resident. Leftover routine medications were sent home with the resident. Prescriptions were called into the resident's pharmacy of choice. During an interview, on 11/6/25 at 11:45 a.m., the Social Services Director indicated a hospital liaison would see the resident prior to admission to the facility to evaluate the resident for needs. Things could slip through this evaluation at times. The policy for wandering or a one-on-one sitter was that the resident's family would be contacted to sit with the resident. For exit seeking, a wanderguard would be placed. The facility would have family or an agency sit with a resident. Either the Social Service Director or family could contact an agency. One specific agency would be contacted first or another provider. The facility's policy indicated the resident would have to be provided safety. If family couldn't afford it, the family would be asked to sit with the resident. Someone would sit with a resident, like a staff member could sit with them. If this had to be done long term, this would take away care from other residents. Another facility would have to be contacted for placement. It could take a few days to locate a placement facility. If a resident was close to the end of a hall with an exit door, they could be moved closer to the center of the hall. This would be tried to get the resident away from the exit doors. If the residents' needs could not be fulfilled with interventions, then it was an issue of safety and during morning meetings this would be discussed. Whatever would be best for their safety. The facility has had family who could not stay with residents, and the resident would discharge for their safety. If needed the resident could stay in her office at times. The sitting agency would have to be financially covered by family. Safety protocols were for a wanderguard to be place. It would alarm when the resident neared an exit door. Residents could sit in her office. The facility could provide 24/7 one on one care, but if this was for an extended amount of time, the resident would be sent to another facility for safety. It was unlikely for a resident to be taken to the Assisted Living (AL) dementia unit, due to accommodation. During an interview, on 11/6/25 at 12:00 p.m., the DON indicated she was not sure what the policy was for exit seeking residents. Staff would sit with the resident until family could arrive to sit with the resident. If family couldn't, the Social Service Director would look for placement elsewhere. The facility asked family to find an outside agency for one-on-one services. The Social Service Director would contact the agency. Management would come into the facility if family could not afford or provide one on one care. She was unsure of the policy. She was unsure if the facility would pay for the agency. It wouldn't be long term. She would want them in a secure unit. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The record for Resident D was reviewed on 11/6/25 at 11:52 a.m. The resident's diagnoses included, but were not limited to, hypotension, bradycardia, paroxysmal atrial fibrillation, dementia, history of falls, and cardiac implant. The nurse's note, dated 10/13/25 at 5:58 p.m., indicated the resident arrived to the facility via ambulance for admission. The nurse's note, dated 10/13/25 at 8:30 p.m., indicated the resident had been found outside the facility attempting to go home. The care plan, dated 10/14/25, indicated the resident was demonstrating exit-seeking behaviors. The interventions, dated 10/14/25, included, but were not limited to one-on-one supervision until alternate placement was found; wanderguard applied to right wrist and monitored as ordered; monitor for wandering triggers; and encourage regular family contact and/or visits with others. The IDT note, dated 10/14/25 at 9:17 a.m., indicated in attendance were the DON, ADON, Therapy director, ED, SSD, and Infection Preventionist. The note indicated the resident had left the facility building and had a fall on the grounds while outside the facility. The staff at the facility called the resident's family to make them aware of the elopement and that they needed to come into the facility and provide one-on-one supervision for the resident's safety. The nurse's note, dated 10/15/25 at 9:33 a.m., indicated Resident D discharged to a higher level of care at a different facility. The facility bus transported the resident and a family member packed and took all of the resident's belongings. The admission Packet, dated 10/28/24, indicated .Many services provided to you, as part of your care at our Facility, are offered by participants in one of our organized healthcare arrangements. These participants include a variety of providers such as physicians, (e.g. MD DO, Podiatrist, Dentist, Optometrist), therapies, (e. g., Physical therapist, Occupational; therapist, Speech therapist), portable radiology units, clinical labs, hospice, caregivers, pharmacies, psychologists, LCSW's, and suppliers (e.g., prosthetic, orthotics). This citation related to Intake 2644284. 3.1-3 (v)(1)