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	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harrison Springs Health Campus	871 Pacer Drive NW 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 - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 35732 Based on record review and interview, the facility failed to ensure the physician was notified and/or follow up with the physician when a resident's surgical wound opened up for 1 of 2 residents reviewed for quality of care. (Resident 20) Findings include: The record for Resident 20 was reviewed on 3/21/25 at 8:30 a.m. The resident's diagnoses included, but were not limited to, acquired absence of the left toe, an open wound of the left foot, gangrene, orthopedic aftercare, and diabetes. The care plan, dated 2/7/25, indicated that the resident had a surgical incision. The interventions included, but were not limited to, administer analgesics per the physician's order, observe the surgical incision for signs of infection, observe the surgical site to ensure well approximated and for non-healing, and treatment to the surgical site as ordered by the physician. The physician's order, dated 2/8/25, indicated staff were to paint the resident's left foot surgical wound with betadine, cover with gauze, wrap with kerlix dressing, and apply ace wrap. The Admission Minimum Data Set (MDS) assessment, dated 2/10/25, indicated the resident was cognitively intact. The resident had a surgical wound and required surgical wound care. The physician's note, dated 2/18/25, indicated the resident's pain in his left foot had worsened. He also reported increased drainage from the surgical site. Due to the increased pain, increased drainage, dorsal flap redness, extending necrosis, and increasingly cool temperature to the dorsal and planter flap of the left foot. The physician believed the resident was going to need a more proximal amputation. The physician indicated the foot had not progressed and only worsened. A call was placed for vascular surgery for the resident to be seen. The nurse's note, dated 2/22/25 at 4:50 p.m., indicated the nurse went to complete the resident's dressing change per the physician's order. The resident's incision sight was observed to have a small 3 milligram (mm) by 1 mm open area along with one staple still left in place. The weekend supervisor was notified, and the treatment was completed. (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
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note, dated 2/22/25 at 5:01 p.m., indicated a staple was observed on the resident's right foot incision. The physician had removed other staples earlier in the week. The physician's office was notified about the staple, but could only leave a voicemail. There were no signs of infection noted. The nurse's note, dated 2/25/25 at 11:30 a.m., indicated the Nurse Practioner (NP) requested to see the resident's left foot. The foot dressing was unwrapped, and the NP examined the site of the resident's amputation. The site had dehisced and had an area on the bottom of foot. New orders were received to send the resident to the hospital emergency room for evaluation and treatment. The record lacked documentation indicating the physician was informed that the residents surgical wound had opened. During an interview, on 3/25/25 at 1:10 p.m., RN 3 indicated the residents wound gradually opened. She did not feel it all happened at once. She did not know what day the wound started to open. On the day the resident was sent to the hospital she was assisting the NP with the residents' dressing change. After removing the dressing, the wound had dehisced, and the resident was sent to the hospital. During an interview, on 3/25/25 at 1:40 p.m., LPN (Licensed Practical Nurse) 4 indicated he walked in the room while the nurse was changing the resident's dressing change. The doctor had removed his staples, and the nurse indicated one staple was left. LPN 4 indicated he called and left a voicemail about the staple. The nurse would have had to call the doctor and inform him about the open incision. He did not know if there was a follow up with the physician or NP. He indicated normally the NP would document in the progress notes, but the LPN did not see any documentation indicating there was a follow up with the physician or NP. During an interview on 3/26/25 at 11:30 a.m., LPN 5 indicated she informed the Supervisor/Charge Nurse that the resident's wound had opened, and a staple was observed. The Supervisor indicated he would notify the physician, and the LPN assumed the physician was informed. She did not recall if there was a follow up with the physician or not. The LPN indicated she notified her supervisor and thought the Supervisor notified the physician about the wound opening. The Physician Notification policy, dated 9/12/17 and revised 12/17/24, included, but was not limited to, .11. Attempts to notify the physician/provider and their response should be documented in the resident electronic health record.12. The 24-Hour report shall be utilized for nurse to nurse communication regarding the status of the notification and response back. 13. If the attending physician, or their practitioner does not respond to notification attempts the Medical Director and Director of Health Services should be notified for further instructions. 3.1-37(a)