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	04/21/2026

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on record review and interview, the facility failed to ensure Resident Council Minutes were recorded monthly for 11 of 13 months and failed to ensure Resident Council Minutes for follow-up responses to grievances were documented for 13 of 13 months reviewed. This had the potential to affect all 52 of 52 residents residing in the facility. Findings include:During an interview, on 4/15/26 at 10:06 a.m., Activity Aide 3 indicated the Resident Council President 18 had the Resident Council Minutes. She found the binder with the Minutes for the last meeting on 4/14/26. During the review of the 4/14/26 Resident Council Minutes, on 4/15/26 at 10:17 a.m., the following concerns were voiced: The menus changed from the printed menu. Residents wanted more assistance with wheelchair transfers. No follow-up for any previous meetings were documented. The Resident Council Minutes in the binder, from April 2025 to April 2026, lacked documentation of minutes since 2023 and 2024, except for the December 2025 and April 2026 Minutes. These were the only Minutes kept by activities in the Resident Council binder since 2023 and 2024. During an interview, on 4/15/26 at 12:35 p.m., the Resident Council President 18 indicated that meetings were held monthly, with staff present, but she didn't document all of the meetings. She indicated she felt it was her responsibility, but she let it slide. During an interview, on 4/16/26 at 8:35 a.m., Activity Aide 4 indicated the residents had monthly meetings. Two Activity Aides helped to direct the meetings. The Resident Council President 18 took notes and Activities staff also took notes. The notes were kept in a binder in their office and she was not aware if anyone had changed or thinned the binder. During a Resident Council Meeting, on 4/17/26 at 9:11 a.m., Resident Council President 18 indicated the residents continued to wait in the bathroom for staff to come back to assist the residents with transfer to their bed or wheelchair. They had not pulled the cord, but once they did, the staff responded quickly. Resident 50 started to cry and indicated it took the staff 30 to 40 minutes to respond, when she was on the bedside toilet or bathroom toilet. She needed consistency with care. The residents at the meeting were unsure if the facility responded to their concerns. There was usually an activity staff member present during the meetings. Resident Council President 18 indicated maybe the notes she took were not good notes, but she did take some notes. The staff copied the notes. Resident 18 kept the notes in her room in a folder. She was unsure what the activity person did with the copy of the meetings. During an observation and interview, on 4/17/26 at 9:50 a.m., Resident Council President 18 presented the minutes she had documented from the last 2 months of meetings in February and March 2026. Sometimes the staff made a copy of the minutes. Sometimes it got lost in the transmission. September 9, 2025 was the only other notes she had documented, before February 2026. The resident indicated she started as Resident Council President in September 2025. The Resident Council notes presented by the President only indicated one to two issues, but no grievance follow-up. The residents in attendance during those meetings were not documented on the February 2026 or March 2026 notes. The notes lacked documentation of follow-up responses by management. During an interview, on 4/17/26 at 10:00 a.m., the Activity Aide 4 indicated she was never at the Resident Council meetings, but Activity Aides 3 or 5 could answer questions. The form that they filled out for the minutes would have been used. During an interview, on 4/17/26 at 10:07 a.m., the Executive (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
	155852	A. Building B. Wing	04/21/2026

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Director (ED) indicated the Activities Director just didn't show up for work after training recently. The Activity Aides verbalized resident grievances presented during the meetings to Administration if they felt they were important. Sometimes they would bring copies of the minutes, if there were concerns. She would review those and let the staff know what follow-up would be completed. During an interview, on 4/20/26 at 9:01 a.m., Activity Aide 3 indicated she and Activity Aide 5 sat in on the Resident Council meetings. When the Activities Director worked in the building, she would sit in on the meetings. She or Activity Aide 5 would set the minutes in front of the previous Activity Director or set them on her desk to enter into the computer. She wasn't sure if the Activities Director documented those on the form on the computer. The Activity staff would take notes and if the Resident Council President wanted a copy, they would provide it to her. They would also write down the names of residents in attendance. She personally didn't have access to the Resident Council form on the computer, where the minutes would be documented, but the ED did and she would ask her to print those out. The Activity Aide opened the Resident Council binder. There was now a note on a form for the March 2026 meeting with residents in attendance. During an interview, on 4/20/26 at 9:59 a.m., the ED indicated a previous Activity Director was not documenting the Resident Council meetings as she should have. The ED had spoken to the Activity Director about this issue, among other things and she had gone back to her old habits. Any staff member could document the Resident Council Minutes in the facility's computer system. The ED presented more Resident Council Minutes at this time. The 10/7/25 Minutes had no documentation on it. She also presented minutes for 12/11/15, 2/10/26, 3/10/26, and 4/14/26. The Minutes had no grievance follow-up documentation other than Old Business was read and approved as revised. The Resident Council Policy, dated April 2025, included, but was not limited to, . 6. Minutes of the meeting will be recorded and maintained for at least 2 years. Minutes will not disclose specific individuals who voice concerns about the Campus. 7. The group facilitator will determine the prevalence of the concern/recommendations voiced to determine appropriate follow-up. 9. Actions taken and/or considerations given to issues will be reported back to the Resident Council at the next meeting. 410 IAC (Indiana Administrative Code) 16.2- 3.1-7(a)(2)

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	04/21/2026

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 - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to hold blood sugar and blood pressure medications when vital signs were out of the physician-ordered set parameters. This deficient practice affected 5 of 8 residents reviewed for medications with set parameters that were to be held based on the vital sign results (Residents 20, 22, 53, 6, and 52)1.The physician's order for Resident 20, dated 12/4/24, indicated the physician or Nurse Practitioner (NP) was to be notified of a systolic blood pressure (SBP-the top number in a blood pressure reading, measuring the maximum pressure in your arteries when your heart muscle contracts and pumps blood) greater than 165 milliliters of mercury (mmHg) or diastolic blood pressure (DBP-the bottom number in a reading, measuring the pressure in your arteries when the heart muscle rests between beats and fills with blood) greater than 100 mmHg taken twice daily. A physician's order, dated 2/3/26, was received for metoprolol succinate extended release 24 hours 50 milligrams (mg). The resident was to receive one tablet daily for high blood pressure. Staff were to hold (not give) for SBP less than 105 mmHg and heart rate less than 60 bpm. The medication was to be given between 6:00 a.m. and 10:00 a.m. The record for Resident 20 was reviewed on 4/20/26 at 11:04 a.m. The diagnoses included, but were not limited to, paroxysmal atrial fibrillation (an irregular, rapid heart rhythm that starts and stops on its own) and portal hypertension (elevated blood pressure within the portal venous system). A Quarterly Minimum Data Set (MDS), dated [DATE], indicated the resident had some trouble with recall but was able to make daily cognitive decisions. A care plan, dated 9/25/24 with a review date of 3/23/26, indicated the resident had the potential for cardiovascular distress related to the diagnoses of atrial fibrillation and hypertension. The goal was for the resident to be free from signs and symptoms of cardiovascular distress. The approaches included, but were not limited to, observe for signs and symptoms of cardiovascular distress and report as needed; medications as ordered, observe for and report side effects as needed; and obtain vital signs as ordered and needed. The review of the February and March 2026 Medication Administration Records (MARs) indicated the set parameters to hold the medications were not followed. The resident's Metoprolol Succinate extended release 25 mg tablet was administered to the resident when the resident's pulse or blood pressure readings were out of the set parameters on the following dates: -On 2/13/26, the resident's pulse was 59. -On 3/1/26, the resident's pulse was 55. -On 3/7/26, the resident's pulse was 56. -On 3/12/26, the resident's Blood pressure reading was SBP 119 over DBP 55. -On 3/13/26, the resident's Blood pressure reading was SBP 108 over DBP 57. -On 3/16/26, the resident's pulse was 57. (continued on next page)

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	04/21/2026

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 - Some	-On 3/20/26, the resident's pulse was 59. The Medical Doctor (MD) or Nurse Practitioner (NP) was to be notified of the resident's SBP greater than 165 bpm or DBP greater than 100 bpm. The resident's blood pressure readings were to be taken twice daily at 6:00 a.m. to 10:00 a.m. The resident's clinical record lacked the MD's or NP's notification related to an elevated SBP of 169 on 2/9/26. 2. The record for Resident 22 was reviewed on 4/17/26 at 2:10 p.m. The diagnoses included, but were not limited to, interstitial pulmonary disease (an umbrella term for over 200 disorders that caused progressive inflammation and irreversible scarring of lung tissue); orthostatic hypotension (a sudden drop in blood pressure within 3 minutes of standing); and atherosclerotic heart disease of native coronary artery without angina pectoris (a condition caused by the buildup of plaque inside artery walls which narrows vessels and restricts oxygen-rich blood flow to the heart). A care plan, dated 4/13/21 with a review date of 3/1/26, indicated the resident had the potential for cardiovascular distress related to diagnoses of congestive heart failure, coronary artery disease, hypertension, high cholesterol and a history of a heart attack. The goal was for the resident to be free from signs and symptoms of cardiovascular distress. The approaches included, but were not limited to, observe for signs and symptoms of cardiovascular distress and report as needed; medications as ordered, observe for and report side effects; and obtain vital signs ordered and needed. A physician's order, dated 1/7/25, indicated the Resident 22 received metoprolol succinate extended release 24 hour tablet, 50 mg, twice daily for hypertension. The staff were to hold the medication if the resident's SBP was less than 100 bpm or DBP was less than 60 bpm. Review of the March 2026 MAR, indicated the set parameters for the staff to hold the resident's medications were not followed. The resident's metoprolol succinate extended release 24 hour tablet was administered on the following dates outside of the parameters: -On 3/30/26 6:00 p.m. to 10:00 p.m. dose, the resident's DBP was 58. -On 3/31/26 6:00 p.m. to 10:00 p.m. dose, the resident's DBP was 57. 3. The clinical record for Resident 53 was reviewed on 4/17/26 at 9:19 a.m. The diagnoses included, but were not limited to, acute respiratory failure with hypoxia (clinical condition where body tissues are deprived of oxygen) and diabetes mellitus (a chronic condition characterized by high blood sugar due to inadequate insulin production). A care plan, dated 3/17/26 with a review date of 3/24/26, indicated the resident had the potential for hypertension and high cholesterol. The goal was for the resident to be free from signs and symptoms of cardiovascular distress. The approaches included, but were not limited to, observe for signs and symptoms of cardiovascular distress and report as needed; medications as ordered, observe for and report side effects; and obtain vital signs ordered and needed. A care plan, dated 3/17/26 with a review 3/24/26, indicated the resident was at risk for hyper and hypoglycemia related to diabetes mellitus. The goal was for the resident to be free of symptoms of hypo or hyperglycemia. The approaches included, but were not limited to, medications per order; (continued on next page)

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	04/21/2026

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 - Some	monitor blood sugars per MD orders; and observe resident for symptoms of hypo or hyperglycemia. A physician's order, dated 3/16/26, indicated the resident was received for insulin lispro pen 100 unit per milliliter (mL) per sliding scale: If the resident blood sugar reading was 150 to 199, the staff were to administer 3 units of insulin; if the resident's blood sugar reading was 200 to 249, the staff were to administer 5 units of insulin; if the resident's blood sugar reading was 250 to 299, the staff were to administer 8 units of insulin; if the resident's blood sugar reading was 300 to 349, the staff were to administer 10 units of insulin; if the resident's blood sugar reading was 350 to 400, the staff were to administer 12 units of insulin; if the resident's blood sugar reading was greater than 400, the staff were to give 14 units and call the MD. The review of the March and April 2026 MARs, indicated the resident's MD was not notified when the resident's blood sugar readings were over 400 on the following dates and times: -On 4/14/26 at 6:30 a.m. to 9:00 a.m. check, the resident's blood sugar reading was 478. -On 4/14/26 at 10:00 a.m. to 12:00 p.m., the resident's blood sugar reading was 461. A physician's order, dated 3/18/26, indicated the resident received metoprolol succinate tablet extended release 24 our tablet twice daily. The staff were to hold the medication if the resident's SBP was less than 105, if the DBP was less than 60, or for a heart rate of less than 60 bpm. The resident received the medication outside of the prescribed administration parameters on the following dates and times: -On 3/27/26 at 6:00 p.m. to 10:00 p.m., the resident's DBP was 59. -On 3/31/26 at 6:00 a.m. to 10:00 a.m., the resident's DBP was 51. -On 4/7/26 at 6:00 p.m. to 10:00 p.m., the resident's DBP was 58. -On 4/15/26 at 6:00 a.m. to 10:00 a.m., the resident's pulse was 59. On 4/20/26 at 2:10 p.m., the Director of Health Services (DHS) indicated that if the physician had given set parameters for certain medications, then nursing would hold the medication and notified the physician that the vital signs fell outside the ordered parameters. On 4/20/26 at 2:20 p.m., the Executive Director (ED) indicated that they had checked with the Clinical Support nurse and there was no set parameters policy to address what they would do. On 4/21/26 at 9:57 a.m., the DHS presented a copy of an action plan for medications not being held per set parameter orders that they indicated was started last week. Review of this action plan indicated they were going to follow all residents who have parameters within the blood pressure medication orders to ensure parameters were met. The action plan failed to identified all residents receiving medication with hold parameters during the survey investigation. Only the same residents were being monitored for the plan of action and not all residents as indicated. 4. The clinical record for Resident 6 was reviewed, on 04/15/26 at 10:00 a.m., the resident's diagnoses included, but were not limited to, atrial fibrillation (an irregular heart rhythm starting in the atria), non-rheumatic aortic valve stenosis (narrowing of the aortic valve), chronic pulmonary edema (continued on next page)

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	04/21/2026

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 - Some	(fluid in the lungs), hypertensive heart, congestive heart failure (chronic condition where the heart does not pump blood efficiently, leading to fluid backup). The care plan, dated 2/28/24 and revised 2/24/26, indicated the resident had potential for cardiovascular distress. The interventions, dated 2/28/24 and revised 2/24/26, included, but were not limited to giving medications as ordered by the physician. A physician's order, with a start date of 10/28/25, indicated the resident was to receive midodrine 10 mg three times daily before meals at 6:00 a.m. to 9:00 a.m., 10:00 a.m. to 12:30 p.m., and 3:30 p.m. to 5:30 p.m. The medication was to be held if the resident's SBP was greater than 130. A physician's order, with a start date of 10/28/25, indicated the resident was to receive metoprolol succinate 25mg once daily and the medication was to be held if the resident's SBP was less than 100 mmHg or if the resident's heart rate was less than 60 beats per minute. The March and April 2026 MAR indicated the resident's midodrine was to be held if the resident's SBP was greater than 130. On the following dates in the EMAR the resident's midodrine was held, but no blood pressure reading was documented on the following dates: 3/6/26, 3/8/26, 3/19/26, 4/2/26, 4/4/26, 4/6/26, 4/8/26, and 4/9/26. The EMAR indicated on 3/18/26, the resident's midodrine was held for a SBP of 122 and the resident's midodrine was administered on 3/28/26 for a SBP of 135. The March and April [DATE] indicated the resident's metoprolol succinate was to be held if the resident's SBP was less than 100, or if the residents pulse was less than 60. The resident's metoprolol was administered out of parameters on 4/7/26 with a SBP of 98 and on 4/12/26 with a SBP of 98. 5. The clinical record for Resident 52 was reviewed on 4/15/26 at 11:00 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure and chronic pain syndrome. The care plan, dated 4/10/26, indicated the resident had potential for cardiovascular distress. The interventions, dated 4/10/26, included, but were not limited to observation for signs and symptoms of cardiovascular distress and report as needed; medications as ordered; and obtain vital signs as ordered. A physician's order, with a start date of 4/11/26, indicated the resident was to receive midodrine 10 mg every 8 hours and the medication was to be held if the resident's SBP was greater than 125. The March and April 2026 EMAR indicated the resident's midodrine was to be held if the resident's SBP was greater than 125. The resident was administered the midodrine out of parameters on 4/12/26 with a SBP of 127. During an interview, 4/17/26 at 9:45 a.m., Registered Nurse (RN) 6 indicated that with abnormal blood pressure or heart rate and physician set parameters a medication would be held, and the physician and DHS would be notified. (continued on next page)

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	04/21/2026

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 - Some	During an interview, 4/20/26 at 10:00 a.m., the Licensed Practical Nurse (LPN) 7 indicated that the medication would be held if outside the physician order parameters. The medication being held would be charted and the physician notified of holding the medication. During an interview, 4/20/25 11:00 a.m., the LPN 8 indicated that if a resident's blood pressure was outside the set parameters, then the medication would be held and notifications made. During an interview on 4/20/26 at 2:10 p.m., the Director of Health Services (DHS) indicated that if the physician had given set parameters for certain medications, then nursing would hold the medication and would notify the physician that the vital signs fell outside the ordered parameters. During an interview on 4/20/26 at 2:20 p.m., the Executive Director (ED) indicated that they had checked with the Clinical Support nurse and there was no set parameters policy to address what they would do. On 4/21/26 at 9:57 a.m., the DHS presented a copy of an action plan for medications not being held per set parameter orders that they indicated was started last week. The review of this action plan indicated they were going to follow all residents who have parameters within the blood pressure medication orders to ensure parameters were met. This plan would continue until 100% compliance was met. It was identified during this review, that the same residents were being monitored the prior week as well as this week. During the final exit meeting, the DHS was asked why the same residents were being monitored every week instead of choosing other residents also with parameter orders to hold the medications. She indicated these were the ones who had issues with the medications not being held per order. 410 IAC (Indiana Administrative Code) 16.2-3.1-37