STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING _____ B. WING _____	03/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a potential injury of unknown origin was immediately reported to the nurse for 1 of 3 residents reviewed for injuries. (Resident E) Finding includes: The clinical record for Resident E was reviewed on 3/16/20 at 8:45 a.m. The resident's [DIAGNOSES REDACTED]. The Reportable Incident, dated 1/13/20, indicated Resident E had swelling of the right hand and light bruising during care. The resident was unable to make staff aware of what happened. The x-ray resulted in a [MEDICAL CONDITION] proximal of right phalanx (finger). The follow up report, dated 1/21/20, indicated upon investigation the resident was resistive and combative during care with staff. While providing care the resident struck at a staff member and missed hitting another staff member and hit their hand against the closet. During an interview with CNA (Certified Nursing Aide) 6, on 3/16/20 at 1:00 p.m., she indicated she and another CNA were providing care to Resident E on 1/11/20. Because the resident had a habit of pushing against the rails, they put them down to provide better care for the resident. The resident went to pinch her and she moved out of the way. The resident got really angry and swung her hand down making contact with the bedside dresser. She did not report the incident because when they looked, the resident had no swelling or bruising. I should have reported it right away. I did report it when they did the investigation after the bruise appeared. During the interviews with CNAs 7, 8, and 9, on 3/16/20 between 9:00 a.m. and 7:30 p.m., staff indicated if a resident was combative with care, they would immediately let the nurse know so she could help with the resident. On 3/16/20 at 6:50 p.m., the Administrator provided a copy of the facility's current policy revised on 4/1/19 titled Indiana Abuse & Neglect & Misappropriation of Property. Review of this policy included, but was not limited to, .IV. Identification of Incidents and Allegations:. 1. The accurate and timely identification of any event which would place our residents at risk is a primary concern of the facility. 2. The following procedure will assist the staff in the identification of incidents and direct them to appropriate steps of intervention. a. Each occurrence of resident incident, bruise, abrasion, or injury of unknown source; or report of alleged abuse, neglect .will be identified and reported to the supervisor and investigated timely . This Federal tag relates to Complaint IN 106. 3.1-28(c)
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure peak levels were obtained and antibiotic given as ordered by the physician for 1 of 3 residents reviewed for physician orders. (Resident H) Finding Includes: The clinical record for Resident H was reviewed on 3/16/20 at 7:14 p.m. The resident's [DIAGNOSES REDACTED]. The care plan, dated 11/27/19 , indicated the resident had an indwelling urinary catheter due to [MEDICAL CONDITION] dysfunction of the bladder. The interventions included, but were not limited to, administer and monitor effectiveness of medications as ordered. The physician's orders [REDACTED]. A physician's progress note, dated 11/29/19, indicated the following physician's orders [REDACTED]. The lab should know exactly what time the dose is given daily so they can schedule the visit on time. Otherwise we draw it ourselves, or take the patient where it can be drawn . Encourage po (oral) fluid as ordered before. [MEDICATION NAME] level from 12/26 is sub therapeutic (ok with me, I am most concerned with toxicity). Still pending levels from: 12/27, 12/28, and 12/29 .Unfortunately the levels were not pulled on the 11/27, 11/28, r/t (related to) 11/27 order did not get in on time, and on 11/28 the RN could not get a sample, I do not know why, but it has to be done within and hour of the completion of medication and lab needed to be called 2 hours in advance. I held the dose and hour tonight and got lab here on time and am waiting the peek for 11/29 . During an interview on 3/16/20 at 7:20 p.m., LPN (Licensed Practical Nurse) 4 indicated if there was a new order from the doctor for a peak and trough, the nurse would call lab and tell them there was a stat lab and what time the lab needed to be there. If an antibiotic was ordered to be given at 4:00 then the lab needed to be there at 3:00 to draw the blood for the trough. If the doctor ordered a peak then the nurse would give the antibiotic at 4:00 and the lab had to be there at 6:00 to draw the peak. The nurse would make all the arrangements with the lab when the order was given. There is absolutely no reason to miss any of it. If that happened they needed to call the doctor. When the results came in they would call the doctor and the pharmacists for any changes. During an interview on 3/16/20 at 8:30 p.m., LPN 5 indicated when there was a doctor's order for a trough the nurse should arrange the time with the lab. The blood needed to be drawn an hour before the antibiotic was given and for the peak the blood was drawn after the antibiotic is given. The results would be faxed or called to the doctor and pharmacy. The pharmacy does the dosing. There was no reason to hold anything. The Physician order [REDACTED].The nurse that takes the physician's orders [REDACTED]. Contact laboratory services, radiology services, pharmacy services, therapy, or other outside vendors as requires to execute the medical order . This Federal tag relates to Complaint IN 563. 3.1-35(a)
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to implement interventions related to one hour checks for a resident with a history of falls for 1 of 3 residents reviewed for accident hazards. (Resident B) Finding includes: The clinical record for Resident B was reviewed, on 3/16/20 at 10:04 a.m. The resident's [DIAGNOSES REDACTED]. The incident note, dated 11/30/19 at 7:39 a.m., indicated the resident had been found laying on her back, at the foot of her bed on the floor, in her room. The IDT (Interdisciplinary Team) follow-up note, dated 12/5/19 at 10:21 a.m., indicated a new intervention of frequent 1 hour checks while in bed would be put into place. The incident note, dated 12/9/19 at 3:40 p.m., indicated the resident was sitting in her reclining chair. When a laundry staff member went into the residents room, the resident was found on the floor. The resident had a red area to the right shoulder and a small raised area to the shoulder as well. The nurses note, dated 12/10/19 at 1:53 a.m., indicated the resident had returned from the hospital and the resident had a broken collarbone. The IDT follow-up note, dated 12/10/19 at 10:32 a.m., indicated a new intervention of frequent 1 hour checks while in wheelchair, recliner, or bed in her room was put into place. The physician's orders [REDACTED]. The clinical record lacked documentation of any 1 hour checks while in bed, in the recliner, or in her room. During an interview on 3/16/19 at 8:34 p.m., LPN (Licensed Practical Nurse) 3 indicated they tried to monitor the resident

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

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.

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) as close as they could. They checked on her in her room but if she was asleep they just checked on her with rounds, which was every 2 hours. During an interview on 3/16/20 at 8:37 p.m., CNA (Certified Nursing Aide) 4 indicated she didn't think there was anything that said specifically how often to check on the resident if she was in her room. She tried to check on her every 2 hours. She was not aware the resident was on any type of 1 hour checks and just assumed all residents were to be checked on a 2 hour schedule. During an interview on 3/16/20 at 8:53 p.m., the Director of Nursing indicated there was not anything for staff to sign off hourly that checks were being done. They did not have documentation of hourly checks. During an interview on 3/16/20 at 8:56 p.m., the Executive Director indicated she did not believe the facility had a policy that addressed the documentation of fall interventions, or a policy on falls. This Federal tag relates to Complaint IN 113. 3.1-45(2)