STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155659	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SELLERSBURG HEALTHCARE CENTER	7823 OLD HWY # 60 SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00369196, IN00369787, and IN00370341. Complaint IN00369196 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677 and F760. Complaint IN00369787 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677, F689, F690, and F760 Complaint IN00370341 - Substantiated. Federal/State deficiencies related to the allegations are cited at F580, F677, F684, F690 and F695. Survey dates: January 5, 6, and 7, 2022 Facility number: 010613 Provider number: 155659 AIM number: 200221040 Census Bed Type: SNF/NF: 99 Total: 99 Census Payor Type: Medicare: 12 Medicaid: 64 Other: 23 Total: 99 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 17, 2022.	F 0000	**Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law.** **The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the complaint survey conducted on January 7, 2022** **Please accept this plan of correction as the provider's credible allegation of compliance.** **The facility would like to respectfully request a desk review.** **Monica Dirbas, LNHA**	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155659	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SELLERSBURG HEALTHCARE CENTER	7823 OLD HWY # 60 SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155659	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SELLERSBURG HEALTHCARE CENTER	7823 OLD HWY # 60 SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on interview and record review, the facility failed to ensure residents' (Residents E and F) representatives were notified of a significant weight loss for 2 of 3 residents reviewed for family notification. Findings include: 1. The clinical record for Resident E was reviewed on 1/6/22 at 9:35 a.m. Diagnoses included, but were not limited to, diabetes and dementia. Review of the facility weight record indicated between 11/4/21 and 12/22/21, the resident had an unexpected weight loss of 12 pounds. The clinical record lacked documentation of family notification related to the weight loss. During an interview on 1/7/22 at 11:13 a.m., LPN (Licensed Practical Nurse) 3 indicated the family should be notified of changes in condition. 2. The clinical record for Resident F was reviewed on 1/6/22 at 10:08 a.m. Diagnoses included, but were not limited to, diabetes, dysphasia, and depression.	F 0580	**F 580 Notify of Changes (Injury/Decline/Room, etc)** **Corrective action for the residents found to have been affected by the deficient practice:** Resident E has been identified as being affected by the deficient practice Resident F has been identified as being affected by the deficient practice **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents having a significant weight loss have the potential to be affected by the deficient practice. A 30 day look back of residents with significant weight loss have been reviewed to ensure residents' representatives were notified of the weight loss. **Measures/systemic changes put into place to ensure the deficient practice does not**	02/07/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155659	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SELLERSBURG HEALTHCARE CENTER	7823 OLD HWY # 60 SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of the facility weight record indicated between 11/4/21 and 12/22/21, the resident had an unexpected weight loss of 11 pounds. The clinical record lacked documentation of family notification related to the weight loss. On 1/7/22 at 3:49 p.m., the Regional Director of Clinical Operations provided a current copy of the document titled "Notification for Changes in Condition" dated 11/30/2018. It included, but was not limited to, "Policy...It is the policy of this facility to provide resident centered care that meets the...physical...needs...of the resident...Notifications...When a change in condition is noted, the nursing staff with contact the resident representative...." This Federal tag relates to Complaint IN00370341 3.1-5(a)(2)		**recur:** The Administrator/Director of Nursing/Unit Manager/Designee held an in-service for licensed nursing staff to provide education and expectations as it relates to "Notification for Changes in Condition" as it relates to notification to resident representatives of significant weight loss in a resident. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Director of Nursing/Unit Manager/Designee will review residents noted to have a significant weight loss for documentation of notification to the resident representative for 5 residents a week for 4 weeks, then 3 residents a week for 4 weeks, then 1 resident a week for 4 weeks for no less than 3 months and compliance is maintained. Any identified concerns will be immediately addressed. The Director of Nursing/Unit Manager/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155659	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SELLERSBURG HEALTHCARE CENTER	7823 OLD HWY # 60 SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on interview and record review, the facility failed to ensure residents (Residents B, D, E, and F) were bathed twice weekly for 4 of 5 residents reviewed for Activities of Daily Living (ADL) Findings include: 1. The clinical record for Resident B was reviewed on 1/5/22 at 1:21 p.m. Diagnoses included, but were not limited to, heart failure and need for assist with personal care. The care plan, dated 12/8/21, indicated the resident had a self-care deficit and required staff assistance with bathing. Review of the shower record indicated between 12/18/21 and 12/30/21, the resident did not receive any showers or bed baths. During an interview on 1/7/22 at 11:10 a.m., CNA (Certified Nursing Aide) 4 indicated residents should be bathed twice weekly. 2. The clinical record for Resident D was reviewed on 1/5/22 at 2:34 p.m. Diagnoses included, but were not limited to, dementia and respiratory failure. The care plan, dated 7/22/21, indicated the resident had a self-care deficit and required staff assistance with bathing and preferred her showers on night shift on Tuesdays and Fridays.	F 0677	**F 677 ADL Care provided to Dependent Residents** **Corrective action for the residents found to have been affected by the deficient practice:** Resident B has been identified as being affected by the deficient practice Resident D has been identified as being affected by the deficient practice Resident E has been identified as being affected by the deficient practice **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected by the deficient practice. An audit of shower/bathing for all residents has been completed to ensure a minimum of 2 shower/bathing days have been scheduled and are reflected on their Kardex. Any identified concerns have been immediately addressed. **Measures/systemic changes put into place to ensure the deficient practice does not**	02/07/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155659	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SELLERSBURG HEALTHCARE CENTER	7823 OLD HWY # 60 SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of the December bathing record indicated the resident received a bath bath on 12/1/21 and 12/18/21. The clinical record lacked documentation of any other bathing. 3. The clinical record for Resident E was reviewed on 1/6/22 at 9:35 a.m. Diagnoses included, but were not limited to, dementia, chronic pain, and heart failure. The care plan, dated 2/5/20, indicated the resident had a self-care deficit and required assistance with bathing on Tuesday and Friday during day shift. Review of the December 2021 shower record indicated the resident did not receive any bed baths between 12/15/21 and 12/30/21. 4. The clinical record for Resident F was reviewed on 1/6/21 at 10:08 a.m. Diagnoses included, but were not limited to, diabetes, dementia, and anxiety. The care plan, dated 9/23/21, indicated the resident had a self-care deficit. The care plan lacked documentation related to bathing assistance and review of the December 2021 shower records lacked documentation of any bathing provided to the resident. On 1/7/22 at 1:19 p.m., the Regional Director of Clinical Operations provided a current copy of the document titled "Personal Bathing and Shower" dated 4/25/2018. It included, but was not limited to, "Policy...It is the policy of this facility to provide resident centered care that meets		**recur:** The Administrator/DON/Designee held an in-service for nursing and direct care staff to provide education and expectations as it relates to “ADL Care-Bathing” to include shower/bathing schedules, documentation and what to do for refusals. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Director of Nursing/Unit Manager/Designee will audit showers/bathing schedule and documentation of completed/refused shower/bathing for 5 residents a week x 4 weeks, then 3 residents a week x 4 weeks, then 1 resident a week for 4 weeks for no less than 3 months and compliance is maintained. Any identified concerns will be immediately addressed. The Director of Nursing/Unit Manager/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155659	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SELLERSBURG HEALTHCARE CENTER	7823 OLD HWY # 60 SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the...physical...needs...of the residents...Bathing preferences should be care planned including type and schedule...Determine resident preference for shower or bathing at bedside...Determine resident preference for AM or PM personal bathing care...Determine resident preference for number of showers during the week...Care plan resident preference...." This Federal tag relates to Complaints IN00369196, IN00369787, and IN00370341 3.1-38(a)(2)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to ensure residents (Residents E and F) skin treatments were completed for 2 of 3 residents reviewed for skin care. Findings include: 1. The clinical record for Resident E was reviewed on 1/6/22 at 9:35 a.m. Diagnosis included, but was not limited to, diabetes. The care plan, dated 6/3/21, indicated the resident was at risk for altered skin integrity and to administer treatments as ordered by the medical	F 0684	**F 684 Quality of Care** **Corrective action for the residents found to have been affected by the deficient practice:** Resident E has been identified as being affected by the deficient practice Resident F has been identified as being affected by the deficient practice **Corrective action taken for**	02/07/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155659	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SELLERSBURG HEALTHCARE CENTER	7823 OLD HWY # 60 SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	provider. The December 2021 treatment administration record indicated the following: -Apply magic butt cream to the left abdominal fold every shift. -Skin prep the left lateral foot every shift. The December 2021 treatment administration record indicated the following: -the treatment to the left abdominal fold was not completed for day shift on 12/9/21, 12/14/21, 12/16/21, 12/22/21 through 12/24/21, or 12/30/21 -the treatment to the left abdominal fold was not completed for night shift on 12/20/21 or 12/31/21 -the treatment to the left lateral heel was not completed for day shift on 12/9/21, 12/14/21, 12/16/21, 12/22/21 through 12/24/21, or 12/30/21 -the treatment to the left lateral heel was not completed for the night shift on 12/20/21 or 12/31/21 During an interview on 1/7/22 at 11:13 a.m., LPN (Licensed Practical Nurse) 3 indicated the treatment administration record should be signed by the nurse to show a treatment was completed. 2. The clinical record for Resident F was reviewed on 1/6/22 at 10:08 a.m. Diagnosis included, but was not limited to, diabetes. The December 2021 treatment administration record indicated to skin prep the right heel every shift. The clinical record lacked documentation that the treatment was completed for day shift on 12/9/21 and 12/16/21.		**those residents having the potential to be affected by the same deficient practice:** All Residents with skin treatments have the potential to be affected by the deficient practice. A 30 day look back of skin treatment documentation has been completed. Any identified concerns have been immediately addressed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/Director of Nursing/Designee held an in-service for licensed nursing staff to provide education and expectations as it relates to the "Skin and Wound Management" with focus on documentation of treatment completion. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Director of Nursing/Unit Manager/Designee will audit completion of treatments being documented for 2 residents 5 time a week x 4 weeks, then 2 residents 3 times a week x 4 weeks, then 2 residents 2 times a week for 4 weeks to ensure documentation is completed for no less than 3 months and compliance is maintained. Any identified concerns will be immediately addressed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155659	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SELLERSBURG HEALTHCARE CENTER	7823 OLD HWY # 60 SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A current copy of the document titled "Monitoring A Wound" dated 7/1/16, included, but was not limited to, "Policy...Each resident/patient is evaluated upon admission...Procedure...Implement wound treatments as ordered. This Federal tag relates to Complaint IN00370341 3.1-37		The Director of Nursing/Unit Manager/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure medications were not left, unattended, in a resident's(Resident C) room for 1 of 1 observations for accidents. Findings include: The clinical record for Resident C was reviewed on 1/5/22 at 1:54 p.m. Diagnoses included, but were not limited to, neuropathy, chronic pain, and bladder spasms. The annual MDS (Minimum Data Set) assessment, dated 12/23/21, indicated the resident's cognition was intact. On 1/6/22 at 1:00 p.m., during an interview with Resident C, QMA (Qualified Medication Aide) 5	F 0689	**F 689 Free of Accident Hazards/Supervision/Devices** **Corrective action for the residents found to have been affected by the deficient practice:** Resident C was identified as being affected by the deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents receiving medications have the potential to be affected by the deficient practice.	02/07/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155659	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SELLERSBURG HEALTHCARE CENTER	7823 OLD HWY # 60 SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	entered the resident's room, place a medication cup with 3 pills on the resident's bedside table, and then exited the room. Resident C indicated they always leave her medications at the bedside and do not typically watch her take the medications. The medications in the medication cup, per the resident, were her afternoon doses of Gabapentin (medication for neuropathy) 800 mg (milligrams), Baclofen (medication for spasms), and Hydrocodone-Acetaminophen (narcotic pain medication) 7.5-325 mg. Resident C was unsure as to why there was pain medication in the cup as she had just taken her 11:00 a.m. dose at 11:30 a.m. At 1:04 p.m. During an interview, on 1/6/22 at 1:02 p.m., QMA 5 reviewed the narcotic count sheet and noticed he had already given Resident C her pain medication. He had forgotten to sign the 11:00 a.m. dose off on the medication administration record which made it appear as if the medication had not been given. QMA 5 indicated it was not policy to leave medications at the bedside. On 1/7/22 at 1:19 p.m., the Regional Director of Clinical Operations provided a current copy of the document titled "Medication Administration" dated 12/14/17. It included, but was not limited to, "Policy...It is the policy of this facility to provide resident centered care...Procedure...Remain with the resident until the medication is swallowed...Medications will be charted when given...." This Federal tag relates to Complaint IN00369787 3.1-45(a)(2)		QMA was immediately redirected and provided education as it relates to medication administration. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/Director of Nursing/Unit Manager/Designee held an in-service for nursing staff to provide education and expectations as it relates to the "Medication Administration" and observing medications being taken at time of medication administration and not leaving medications at the bedside. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Director of Nursing/Unit Manager/Designee will complete a medication administration observation for 3 residents a week x 4 weeks, then 2 residents a week x 4 weeks, then 1 resident with a week for 4 weeks to ensure medications are observed to be taken at time of administration and not left at the bedside. This will occur for no less than 3 months and compliance is maintained. The DON/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155659	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SELLERSBURG HEALTHCARE CENTER	7823 OLD HWY # 60 SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			committee will determine when 100% compliance is achieved or if ongoing monitoring is required. **F 690 Bowel/Bladder Incontinence, Catheter, UTI** **Corrective action for the residents found to have been affected by the deficient practice:** Resident D was identified as being affected by the deficient practice. Resident K was identified as being affected by the deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents with foley catheters have the potential to be affected by the deficient practice. An audit of the last 30 days for residents having foley catheters has been completed to ensure foley catheter output has been documented as ordered by the physician. Any identified concerns were immediately addressed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/DON/Designee held an in-service for nursing staff to provide education and expectations as it relates to the "Catheter Care" and documentation of catheter output per physician order **Corrective actions to be**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155659	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SELLERSBURG HEALTHCARE CENTER	7823 OLD HWY # 60 SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			monitored to ensure the deficient practice will not recur: The DON/Unit Manager/Designee will audit 3 residents with catheters a week x 4 weeks, then 2 residents with catheters a week x 4 weeks, then 1 resident with a catheter a week for 4 weeks to ensure documentation of catheter output has been completed per physician orders on the TAR. This will occur for no less than 3 months and compliance is maintained. The DON/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
F 0690 SS=E Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155659	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SELLERSBURG HEALTHCARE CENTER	7823 OLD HWY # 60 SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to ensure Indwelling catheter care was completed and to ensure staff monitored catheter output, as ordered by the physician, for 4 of 4 residents reviewed for Indwelling Foley catheters. (Residents C, E, F, and G) Findings include: 1. The clinical record for Resident C was reviewed on 1/5/22 at 1:54 p.m. Diagnosis included, but was not limited to, stage 4 sacral pressure ulcer. The care plan, dated 9/8/21, indicated the resident had an Indwelling Foley catheter and to provide catheter care every shift.	F 0690	**F 690 Bowel/Bladder Incontinence, Catheter, UTI** **Corrective action for the residents found to have been affected by the deficient practice:** Resident C was identified as being affected by the deficient practice. Resident E was identified as being affected by the deficient practice. Resident F was identified as being affected by the deficient practice. Resident G was identified as being affected by the deficient practice. **Corrective action taken for those residents having the**	02/07/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155659	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SELLERSBURG HEALTHCARE CENTER	7823 OLD HWY # 60 SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The December 2021 MAR (medication administration record) indicated the following: -Cleanse the Indwelling Foley catheter with soap and water every shift -Measure and record output The clinical record lacked documentation of Foley catheter care and the measurement of urine output on 12/9/21 and 12/14/21 during the day shift. The January 2022 MAR indicated to cleanse the resident's Foley catheter with soap and water every shift and to measure/record urine output. The clinical record lacked documentation of Foley catheter care and the measurement of urine output between 1/1/22 and 1/5/22. During an interview on 1/7/22 at 11:13 a.m., LPN (Licensed Practical Nurse) 3 indicated once care was provided, staff would sign off on the treatment record to show care was completed. 2. The clinical record for Resident E was reviewed on 1/6/22 at 9:35 a.m. Diagnosis included, but was not limited to, acute kidney failure. The care plan, dated 2/5/20, indicated the resident had an Indwelling suprapubic catheter and to monitor output. The December 2021 and January 2022 treatment administration record indicated to cleanse the catheter with soap and water every shift and to measure/record output every shift. The clinical record indicated catheter cleansing and the measurement of urine output was not		**potential to be affected by the same deficient practice:** All residents with foley catheters have the potential to be affected by the deficient practice. An audit of the last 30 days for residents having foley catheters has been completed to ensure foley catheter output has been completed as ordered by the physician. Any identified concerns were immediately addressed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/Director of Nursing/Designee held an in-service for nursing staff to provide education and expectations as it relates to the "Catheter Care" and documentation of catheter output per physician order. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON/Unit Manager/Designee will audit 3 residents with catheters a week x 4 weeks, then 2 residents with catheters a week x 4 weeks, then 1 resident with a catheter a week for 4 weeks to ensure documentation of catheter output has been completed per physician orders. This will occur for no less than 3 months and compliance is maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155659	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SELLERSBURG HEALTHCARE CENTER	7823 OLD HWY # 60 SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	completed for day shift on 12/9/21, 12/14/21, 12/16/21, 12/22/21 through 12/24/21, and 12/30/21; catheter cleansing for night shift was not completed on 12/31/21, 1/1/22, and 1/3/22; and urine output was not documented for night shift on 12/20/21, 12/30/21, 12/31/21, 1/1/22, 1/2/22, and 1/3/22. 3. The clinical record for Resident F was reviewed on 1/6/22 at 10:08 a.m. Diagnosis included, but was not limited to, obstructive uropathy. The care plan, dated 9/23/21, indicated the resident had an Indwelling suprapubic catheter and to provide catheter care every shift. The December 2021 and January 2022 treatment administration record indicated to cleanse the catheter with soap and water every shift and to measure/record output every shift. The clinical record indicated catheter cleansing and the measurement of urine output was not completed for day shift on 12/9/21, 12/16/21, 12/22/21 through 12/24/21, and 12/30/21; catheter cleansing for night shift was not completed on 12/31/21, 1/1/22, and 1/3/22; and urine output was not documented for night shift on 12/20/21, 12/30/21, 12/31/21, 1/1/22, 1/2/22, and 1/3/22. 4. The clinical record for Resident G was reviewed on 1/6/22 at 1:30 p.m. Diagnosis included, but was not limited to, neuromuscular dysfunction of the bladder. The care plan, dated 2/22/21, indicated the resident had an Indwelling Foley catheter and to provide catheter care every shift. The January 2022 treatment administration record		The DON/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155659	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SELLERSBURG HEALTHCARE CENTER	7823 OLD HWY # 60 SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated to provide Foley catheter care and measure/record output every shift. The January 2022 treatment administration lacked documentation of the measurement of urine output and for catheter care on 1/4/22 and 1/5/22. On 1/7/22 at 1:19 p.m., the Regional Director of Clinical Operations provided a current copy of the document titled "Catheter Care" dated 5/1/2017. It included, but was not limited to, "Policy...It is the policy of this facility to provide resident care...Catheter care is performed at least twice daily on residents that have indwelling catheters...." This Federal tag relates to Complaints IN00369787 and IN00370341.			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on interview and record review, the facility failed to ensure an antibiotic was administered to a resident (Resident F) with bronchitis, as ordered by the physician, for 1 of 3 residents reviewed for respiratory care. Findings include:	F 0695	**F695 Respiratory/Tracheostomy Care and Suctioning** **Corrective action for the residents found to have been affected by the deficient practice:** Resident F was identified as being affected by the deficient practice.	02/07/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155659	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SELLERSBURG HEALTHCARE CENTER	7823 OLD HWY # 60 SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The clinical record for Resident F was reviewed on 1/6/22 at 10:08 a.m. Diagnosis included, but was not limited to, bronchitis (inflammation of the bronchial tubes). The physician's order, dated 12/23/21 at 6:27 a.m., indicated the resident was to receive Amoxicillin-Potassium Clavulanate (antibiotic for bacterial infection) 875-125 mg (milligrams), one tablet every 12 hours for bronchitis at 8:00 a.m. and 8:00 p.m. The care plan, dated 12/23/21, indicated the resident had bronchitis and to administer antibiotics per medical provider's orders. The December 2021 medication administration record indicated the medication was not administered on 12/23/21 at 8:00 a.m., 12/24/21 at 8:00 a.m., and 12/28/21 at 8:00 p.m. During an interview on 1/7/22 at 11:13 a.m., LPN (Licensed Practical Nurse) 3 indicated the medication administration record should be signed off to show the medication was administered. On 1/7/22 at 1:19 p.m., the Regional Director of Clinical Operations provided a current copy of the document titled "Medication Administration" dated 12/14/17. It included, but was not limited to, "Medication Administration Record - the legal documentation for medication administration...Policy...It is the policy of this facility to provide resident centered care...Medications will be charted when given...." This Federal tag relates to Complaint IN00370341 3.1-47(a)(6)		**Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents requiring an antibiotic have the potential to be affected by the deficient practice. A 30 day look back of antibiotic orders has been completed to ensure administration was completed as ordered by the physician. Any identified concerns were immediately addressed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/Director of Nursing/Unit Manager/Designee held an in-service for licensed nursing staff to provide education and expectations as it relates to "Medication Administration" with focus on antibiotics administered as ordered by the physician. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Director of Nursing/Unit Manager/Designee will audit residents requiring an antibiotic to ensure administration has been completed as ordered by the physician as follows: 5 residents a week x 4 weeks, then 3 residents a week x 4 weeks, then 1 resident a week for 4 weeks for no less than 3 months and compliance is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155659	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SELLERSBURG HEALTHCARE CENTER	7823 OLD HWY # 60 SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			maintained. Any identified concerns will be immediately addressed. The DON/Unit Manager/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on interview and record review, the facility failed to ensure medications were administered as ordered (Resident B) and failed to ensure pre-op orders were implemented for a resident (Resident C) for 2 of 3 residents reviewed for significant medication errors. Findings include: 1. The clinical record for Resident B was reviewed on 1/5/22 at 1:21 p.m. Diagnosis included, but was not limited to, left lower extremity deep vein thrombosis. The care plan, dated 12/8/21, indicated the resident had a deep vein thrombosis to his left lower extremity and to administer anti-coagulant medications as ordered by the medical provider. The admission order, dated 12/7/21, indicated the	F 0760	**F 760 Residents are Free of Significant Med Errors** **Corrective action for the residents found to have been affected by the deficient practice:** Resident B was identified as being affected by the deficient practice. Resident C was identified as being affected by the deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Any resident a procedure requiring pre-op orders has the potential to be affected by the deficient practice. A 30 day look back has been completed for review of residents	02/07/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155659	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SELLERSBURG HEALTHCARE CENTER	7823 OLD HWY # 60 SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident was to receive Apixaban (blood thinner) 5 mg (milligrams) twice daily. The clinical record lacked documentation of the administration of the medication for evening shift on 12/9/21, 12/10/21, 12/13/21, 12/14/21, 12/18/21, 12/19/21, 12/23/21, and 12/24/21. During an interview on 1/7/22 at 11:13 a.m., LPN (Licensed Practical Nurse) 3 indicated the medication administration record should be signed off to show the medication was administered. 2. The clinical record for Resident C was reviewed on 1/5/22 at 1:54 p.m. Diagnoses included, but were not limited to, peripheral vascular disease and atrial fibrillation. The progress note, dated 9/22/21 at 3:07 p.m., indicated the surgeon's office had called with pre-operative orders given and verified per the nurse practitioner. The resident was scheduled for surgery on 10/5/21. Review of the pre-op orders report, dated 9/28/21, indicated the resident's apixaban (eliquis) 5 mg tablet should be stopped 3 days prior to the procedure. Review of the October 2021 medication administration record indicated the medication was not stopped as ordered. During an interview on 1/6/22 at 9:52 a.m., the Regional Director of Clinical Operations indicated the resident had not voiced concerns about the surgery for a couple of weeks. We discovered the medication errors of the pre-operative orders and educated staff on 10/18/21.		who have had a procedure to ensure pre-op orders were implemented. Any identified concerns were immediately addressed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/Director of Nursing/Unit Manager/Designee held an in-service with licensed nursing staff to provide education and expectations as it relates to "Medication Administration" with focus on implementation of Pre-op orders. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Administrator/Director of Nursing/Unit Manager/Designee will audit residents requiring pre op order implementation for completion as follows: 3 residents a week x 4 weeks, then 2 residents a week x 4 weeks, then 1 resident a week for 4 weeks for no less than 3 months and compliance is maintained. Any identified concerns will be immediately addressed. The Director of Nursing/Unit Manager/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155659	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SELLERSBURG HEALTHCARE CENTER	7823 OLD HWY # 60 SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 1/7/22 at 1:19 p.m., the Regional Director of Clinical Operations provided a current copy of the document titled "Medication Administration" dated 12/14/17. It included, but was not limited to, "Medication Administration Record - the legal documentation for medication administration...Policy...It is the policy of this facility to provide resident centered care...Medications will be charted when given...." On 1/7/22 at 1:19 p.m., the Regional Director of Clinical Operations provided a current copy of the document titled "Physician Orders" dated 12/1/18. It included, but was not limited to, "Policy...It is the policy of this facility to provide resident centered care...Execution of Order...The nurse that takes the physician order will be responsible for executing the order...Update MAR...with...new orders...." This Federal tag relates to Complaint IN00369196 and IN00369787 3.1-48(c)(2)		committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	