	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155659	î î	ILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/07/2022	
NAME OF	PROVIDER OR SUPPLIE	R	-		address, city, state, zip cod DLD HWY # 60		
SELLER	SBURG HEALTHC	ARE CENTER		SELLE	RSBURG, IN 47172		
(X4) ID PREFIX TAG	(EACH DEFICIE)	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
0000							
Bldg. 00	IN00369196, IN00 Complaint IN0036 Federal/State defice allegations are cite Complaint IN0036 Federal/State defice allegations are cite Complaint IN0037 Federal/State defice allegations are cite F695. Survey dates: Janu Facility number: Co Provider number: AIM number: 200 Census Bed Type: SNF/NF: 99 Total: 99 Census Payor Type Medicare: 12 Medicaid: 64 Other: 23 Total: 99 These deficiencies accordance with 4	155659 221040 e: reflect State Findings cited in	F 00	000	Preparation or execution of this plan of correction does constitute admission or agreement of provider of th truth of the facts alleged or conclusions set forth on the State of Deficiencies. The P of Correction is prepared an executed solely because it required by the position of Federal and State Law. The Plan of Correction is submitted in order to respo to the allegation of noncompliance cited during the complaint survey conducted on January 7, 20 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	not e lan nd is nd 222	

## LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 02/28/2022

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.

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155659	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING STREET ADDRESS CITY STATE ZIP CO			(X3) DATE SURVEY COMPLETED 01/07/2022	
	PROVIDER OR SUPPLIE			7823 O	address, city, state, zip c DD HWY # 60 RSBURG, IN 47172	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION iv)(15)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S) CROSS-REFERENCED TO THE / DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
- 0580 SS=D Bldg. 00	Notify of Changer §483.10(g)(14) N (i) A facility must resident; consult physician; and no her authority, the when there is- (A) An accident in results in injury a requiring physicia (B) A significant of physical, mental, (that is, a deterion psychosocial stat conditions or clini (C) A need to alte (that is, a need to form of treatment consequences, o of treatment); or (D) A decision to resident from the §483.15(c)(1)(ii). (ii) When making (g)(14)(i) of this s ensure that all per in §483.15(c)(2) i upon request to t (iii) The facility m resident and the any, when there if (A) A change in r assignment as sp (B) A change in r or State law or re paragraph (e)(10 (iv) The facility m	s (Injury/Decline/Room, etc.) otification of Changes. immediately inform the with the resident's otify, consistent with his or resident representative(s) hvolving the resident which and has the potential for an intervention; change in the resident's or psychosocial status ration in health, mental, or us in either life-threatening cal complications); er treatment significantly o discontinue an existing due to adverse r to commence a new form transfer or discharge the facility as specified in notification under paragraph ection, the facility must rtinent information specified s available and provided he physician. ust also promptly notify the resident representative, if s- oom or roommate pecified in §483.10(e)(6); or esident rights under Federal gulations as specified in ) of this section. ust record and periodically ss (mailing and email) and					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155659	(X2) MULTIPLE A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 01/07/2022	
	PROVIDER OR SUPPLIEI		7823	et address, city, state, zip c OLD HWY # 60 LERSBURG, IN 47172	COD	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	CROSS-REFERENCED TO THE A	RRECTION HOULD BE APPROPRIATE	(X5) COMPLETION
TAG	representative(s).	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	<ul> <li>§483.10(g)(15)</li> <li>Admission to a confacility that is a condefined in §483.5</li> <li>admission agreen configuration, incluting that comprise the and must specify room changes be under §483.15(c))</li> <li>Based on interview failed to ensure resire presentatives were weight loss for 2 of notification.</li> <li>Findings include: <ol> <li>The clinical recoord on 1/6/22 at 9:35 a.</li> <li>were not limited to the facilies between 11/4/21 are unexpected weight</li> </ol> </li> <li>Review of the facilies the conditional record notification related between 11/4/21 are unexpected weight</li> <li>The clinical record notification related During an interview (Licensed Practical should be notified on 2. The clinical recoord on 1/6/22 at 10:08 are conditioned between 10.5 and the conditioned be notified on 2. The clinical recoord on 1/6/22 at 10:08 are conditioned between 10.5 and the conditioned between 10.5 and the clinical recoord condition t</li></ul>	emposite distinct part. A emposite distinct part (as ) must disclose in its nent its physical uding the various locations composite distinct part, the policies that apply to tween its different locations (9). and record review, the facility idents' (Residents E and F) e notified of a significant C3 residents reviewed for family rd for Resident E was reviewed m. Diagnoses included, but , diabetes and dementia. ity weight record indicated id 12/22/21, the resident had an loss of 12 pounds. lacked documentation of family	F 0580	F 580 Notify of Chang (Injury/Decline/Room, Corrective action for residents found to ha affected by the deficie practice: Resident E has been in being affected by the of practice Resident F has been in being affected by the of practice Corrective action take those residents having a weight loss have the p be affected by the defi practice. All residents having a weight loss have the p be affected by the defi practice. A 30 day look back of with significant weight been reviewed to ensu- representatives were r weight loss. Measures/systemic cl into place to ensure t deficient practice doe	, etc) the ve been ent dentified as deficient dentified as deficient en for ng the ed by the ce: significant otential to cient residents loss have ure residents' notified of the hanges put he	02/07/2022

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0GEE11 Facility ID: 010613

If continuation sheet

Page 3 of 20

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 155659	(X2) MULT A. BUILI B. WING	DING	NSTRUCTION (X. 00	(X3) DATE SURVEY COMPLETED 01/07/2022	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD LD HWY # 60		
SELLER	SBURG HEALTHC	ARE CENTER	S	BELLER	RSBURG, IN 47172		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	Т	AG	DEFICIENCY)		DATE
		lity weight record indicated			recur:		
		nd $12/22/21$ , the resident had an			The Administrator/Director of		
	unexpected weight	t loss of 11 pounds.			Nursing/Unit Manager/Designee		
	751 1' 1 1				held an in-service for licensed		
		l lacked documentation of family l to the weight loss.			nursing staff to provide education	n	
	nouncation related	i to the weight loss.			and expectations as it relates to "Notification for Changes in		
	On $1/7/22$ at $3.40$	p.m., the Regional Director of			Condition" as it relates to		
		s provided a current copy of the			notification to resident		
	-	Notification for Changes in			representatives of significant		
		1/30/2018. It included, but was			weight loss in a resident.		
		licyIt is the policy of this			Corrective actions to be		
		resident centered care that			monitored to ensure the		
	meets thephysica				deficient practice will not		
		ionsWhen a change in			recur:		
	condition is noted,	the nursing staff with contact			The Director of Nursing/Unit		
	the resident repres	entative"			Manager/Designee will review		
					residents noted to have a		
	This Federal tag re	elates to Complaint IN00370341			significant weight loss for		
					documentation of notification to		
	3.1-5(a)(2)				the resident representative for 5		
					residents a week for 4 weeks,		
					then 3 residents a week for 4		
					weeks, then 1 resident a week fo		
					4 weeks for no less than 3 month	ns	
					and compliance is maintained. Any identified concerns will be		
					immediately addressed.		
					The Director of Nursing/Unit		
					Manager/Designee will present t	he	
					results of these audits monthly to		
					the QAPI committee for no less	_	
					than 3 months. Any patterns tha	at	
					are identified will have an Action		
					Plan initiated. The QAPI		
					committee will determine when		
					100% compliance is achieved or	if	
					ongoing monitoring is required.		
	1				1		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155659	(X2) MULTIPLE A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 01/07/2022	
	PROVIDER OR SUPPLIEI		7823	et address, city, state, zip cod 8 OLD HWY # 60 LERSBURG, IN 47172		
(X4) ID PREFIX TAG • 0677	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
SS=E Bldg. 00	ADL Care Provide §483.24(a)(2) A recarry out activities necessary service nutrition, groomin hygiene; Based on interview failed to ensure res F) were bathed twice reviewed for Active Findings include: 1. The clinical record on 1/5/22 at 1:21 p were not limited to assist with personal The care plan, date resident had a self- assistance with bath Review of the show 12/18/21 and 12/30 any showers or bed During an interview (Certified Nursing should be bathed tw 2. The clinical record on 1/5/22 at 2:34 p were not limited to failure.	d 12/8/21, indicated the care deficit and required staff hing. ver record indicated between 0/21, the resident did not receive 1 baths. v on 1/7/22 at 11:10 a.m., CNA Aide) 4 indicated residents vice weekly. rd for Resident D was reviewed .m. Diagnoses included, but , dementia and respiratory	F 0677	F 677 ADL Care provided to Dependent Residents Corrective action for the residents found to have bee affected by the deficient practice: Resident B has been identified being affected by the deficient practice Resident D has been identified being affected by the deficient practice Resident E has been identified 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 potentified be affected by the deficient practice. An audit of shower/bathing for residents has been completed ensure a minimum of 2 shower/bathing days have be scheduled and are reflected of their Kardex. Any identified concerns have been immedia	ed as at ed as at ed as at ed as at at he al to r all d to een on	02/07/2022
	resident had a self- assistance with bath	d 7/22/21, indicated the care deficit and required staff hing and preferred her showers uesdays and Fridays.		addressed. Measures/systemic changes into place to ensure the deficient practice does not	s put	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0GEE11 Facility ID: 010613

If continuation sheet Page 5 of 20

#### STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 01/07/2022 155659 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7823 OLD HWY # 60 SELLERSBURG HEALTHCARE CENTER SELLERSBURG, IN 47172 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE recur: Review of the December bathing record indicated The Administrator/DON/Designee the resident received a bath bath on 12/1/21 and held an in-service for nursing and 12/18/21. direct care staff to provide education and expectations as it The clinical record lacked documentation of any relates to "ADL Care-Bathing" to other bathing. include shower/bathing schedules, documentation and what to do for 3. The clinical record for Resident E was reviewed refusals. on 1/6/22 at 9:35 a.m. Diagnoses included, but Corrective actions to be were not limited to, dementia, chronic pain, and monitored to ensure the heart failure. deficient practice will not recur: The care plan, dated 2/5/20, indicated the resident The Director of Nursing/Unit had a self-care deficit and required assistance with Manager/Designee will audit bathing on Tuesday and Friday during day shift. showers/bathing schedule and documentation of Review of the December 2021 shower record completed/refused shower/bathing indicated the resident did not receive any bed for 5 residents a week x 4 weeks, baths between 12/15/21 and 12/30/21. then 3 residents a week x 4 weeks, then 1 resident a week for 4. The clinical record for Resident F was reviewed 4 weeks for no less than 3 months on 1/6/21 at 10:08 a.m. Diagnoses included, but and compliance is maintained. were not limited to, diabetes, dementia, and Any identified concerns will be anxiety. immediately addressed. The Director of Nursing/Unit The care plan, dated 9/23/21, indicated the Manager/Designee will present the resident had a self-care deficit. results of these audits monthly to the QAPI committee for no less The care plan lacked documentation related to than 3 months. Any patterns that bathing assistance and review of the December are identified will have an Action Plan initiated. The QAPI 2021 shower records lacked documentation of any bathing provided to the resident. committee will determine when 100% compliance is achieved or if On 1/7/22 at 1:19 p.m., the Regional Director of ongoing monitoring is required. 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

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Page 6 of 20

02/28/2022 PRINTED:

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED OMB NO. 0938-039

0GEE11

Facility ID: 010613

If continuation sheet

PRINTED: 02/28/2022 OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155659	(X2) MULTIPLE A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/07/2022	
	PROVIDER OR SUPPLII SBURG HEALTHO		7823	et address, city, state, zip cod OLD HWY # 60 .ERSBURG, IN 47172	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 0684 SS=D Bldg. 00	preferences should type and schedule for shower or bath resident preference bathing careDet number of shower resident preference This Federal tag re IN00369787, and 3.1-38(a)(2) 483.25 Quality of Care § 483.25 Quality Quality of Care is applies to all treat facility residents, comprehensive a facility must ensu- treatment and ca professional star comprehensive p and the resident Based on interview failed to ensure re treatments were car reviewed for skin Findings include: 1. The clinical rec on 1/6/22 at 9:35 a not limited to, dia The care plan, dat was at risk for alto	elates to Complaints IN00369196, IN00370341 of care a fundamental principle that atment and care provided to Based on the assessment of a resident, the are that residents receive are in accordance with adards of practice, the berson-centered care plan, s' choices. w and record review, the facility sidents (Residents E and F) skin ompleted for 2 of 3 residents care.	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 being affected by the deficient practice Resident F has been identified being affected by the deficient practice Corrective action taken for	l as

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILD		DNSTRUCTION	(X3) DATE COMPL	
IND I LAN	or connection	155659	B. WING		<u> </u>	01/07	
NAME OF	PROVIDER OR SUPPLIE	ĒR			ADDRESS, CITY, STATE, ZIP COD DLD HWY # 60		
SELLER	SBURG HEALTHO	CARE CENTER			RSBURG, IN 47172		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	П	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		DR LSC IDENTIFYING INFORMATION	T	AG			DATE
	provider.				those residents having the		
	The December 20	21 treatment administration			potential to be affected by th	e	
	record indicated th				same deficient practice: All Residents with skin treatme	onto	
		ie fondwillig.			have the potential to be affect		
	-Apply magic butt	cream to the left abdominal fold			by the deficient practice.	cu -	
	every shift.	erean to the fort abdominar ford			A 30 day look back of skin		
		lateral foot every shift.			treatment documentation has		
				been completed. Any identifie	d		
	The December 202	21 treatment administration			concerns have been immediat		
	record indicated th	ne following:			addressed.	,	
		-			Measures/systemic changes	put	
	-the treatment to th	he left abdominal fold was not			into place to ensure the	•	
	completed for day	shift on 12/9/21, 12/14/21,			deficient practice does not		
	12/16/21, 12/22/21	1 through 12/24/21, or 12/30/21			recur:		
	-the treatment to the	-the treatment to the left abdominal fold was not			The Administrator/Director of		
	completed for night			Nursing/Designee held an			
	-the treatment to the			in-service for licensed nursing	staff		
	completed for day			to provide education and			
		12/16/21, 12/22/21 through 12/24/21, or 12/30/21			expectations as it relates to th	е	
		he left lateral heel was not			"Skin and Wound Managemer		
	-	night shift on 12/20/21 or			with focus on documentation of	of	
	12/31/21				treatment completion.		
					Corrective actions to be		
	Ũ	w on 1/7/22 at 11:13 a.m., LPN			monitored to ensure the		
		I Nurse) 3 indicated the			deficient practice will not		
		tration record should be signed ow a treatment was completed.			recur:		
	by the nurse to sho	ow a treatment was completed.			The Director of Nursing/Unit Manager/Designee will audit		
	2 The clinical rec	ord for Resident F was reviewed			completion of treatments being	a	
		a.m. Diagnosis included, but			documented for 2 residents 5	Э	
	was not limited to.				time a week x 4 weeks, then 3	2	
		,			residents 3 times a week x 4	-	
	The December 202	21 treatment administration			weeks, then 2 residents 2 time	es a	
		skin prep the right heel every			week for 4 weeks to ensure		
	shift.				documentation is completed for	or no	
					less than 3 months and		
	The clinical record	l lacked documentation that the			compliance is maintained. An	у	
	treatment was com	pleted for day shift on 12/9/21			identified concerns will be		
	and 12/16/21.				immediately addressed.		

Event ID: 0GEE11 Facility ID: 010613

If continuation sheet Page 8 of 20

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	(X2) MULTIPLE CONSTRUCTION			ΞY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	DING	00	COMPLETED		
		155659	B. WING			01/07/2022	2022	
NAME OF	PROVIDER OR SUPPLIE	<b>P</b>	S	TREET AD	DRESS, CITY, STATE, ZIP COD			
					HWY # 60			
SELLER	SBURG HEALTHO	ARE CENTER	\$	ELLERS	BURG, IN 47172			
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	Π	D	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PRE	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COM	IPLETION	
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	T.	AG	DEFICIENCY)		DATE	
					The Director of Nursing/Unit			
		the document titled			/lanager/Designee will present			
	-	ound" dated 7/1/16, included,			esults of these audits monthly			
		d to, "PolicyEach			he QAPI committee for no less			
	resident/patient is			t	han 3 months. Any patterns th	nat		
		dureImplement wound		a	are identified will have an Actio	on		
	treatments as orde		F	Plan initiated. The QAPI				
			c	committee will determine when	1			
	This Federal tag re		1	00% compliance is achieved	or if			
			c	ongoing monitoring is required				
	3.1-37							
0689	483.25(d)(1)(2)							
SS=D	Free of Accident							
Bldg. 00	Hazards/Supervi	sion/Devices						
	§483.25(d) Accid	lents.						
	The facility must	ensure that -						
	§483.25(d)(1) Th	e resident environment						
	remains as free of	of accident hazards as is						
	possible; and							
	§483.25(d)(2)Ea	ch resident receives						
	adequate superv	ision and assistance devices						
	to prevent accide	ents.						
		ion, interview and record	F 0689	)		02/	07/202	
		failed to ensure medications			689 Free of Accident			
	were not left, unat	tended, in a resident's(Resident			lazards/Supervision/Devices	, I		
	C) room for 1 of 1	observations for accidents.		C	Corrective action for the			
	Findings include:			a	esidents found to have been Iffected by the deficient practice:			
	The clinical record	d for Resident C was reviewed			Resident C was identified as be	eina		
		5.m. Diagnoses included, but			affected by the deficient practic	•		
	-	o, neuropathy, chronic pain, and			Corrective action taken for	~.		
		he annual MDS (Minimum Data			hose residents having the			
	· ·	ated 12/23/21, indicated the			nose residents having the potential to be affected by the			
	resident's cognitio				-	-		
	resident's cognitio	n was miaci.			ame deficient practice:			
	$O_{m} 1/6/22 \rightarrow 1.00$	a an draing on inter-i-i			All residents receiving medicat			
		p.m., during an interview with			have the potential to be affecte	a		
	Resident C, QMA	(Qualified Medication Aide) 5		b	by the deficient practice.			

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILD		NSTRUCTION 00	. ,	E SURVEY LETED
		155659	B. WING			01/07	7/2022
NAME OF	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP COD		
SELLER	SBURG HEALTHC	ARE CENTER			RSBURG, IN 47172		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	п	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PRE	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	T	AG	DEFICIENCY)		DATE
	entered the residen	t's room, place a medication			QMA was immediately redirec	ted	
	cup with 3 pills on	the resident's bedside table,			and provided education as it		
	and then exited the	e room. Resident C indicated			relates to medication		
	they always leave	her medications at the bedside			administration.		
	and do not typicall	y watch her take the			Measures/systemic changes	put	
		nedications in the medication			into place to ensure the		
	cup, per the resider	nt, were her afternoon doses of			deficient practice does not		
	Gabapentin (medic	cation for neuropathy) 800 mg			recur:		
	(milligrams), Bacl	ofen (medication for spasms),			The Administrator/Director of		
	and Hydrocodone-	Acetaminophen (narcotic pain			Nursing/Unit Manager/Designe	ee	
	medication) 7.5-32	25 mg. Resident C was unsure as			held an in-service for nursing	staff	
	to why there was p	ain medication in the cup as			to provide education and		
	she had just taken	her 11:00 a.m. dose at 11:30 a.m.			expectations as it relates to the	е	
	At 1:04 p.m.				"Medication Administration" ar	nd	
					observing medications being ta	aken	
	During an intervie	w, on 1/6/22 at 1:02 p.m., QMA 5			at time of medication		
	reviewed the narco	tic count sheet and noticed he			administration and not leaving		
	had already given	Resident C her pain medication.			medications at the bedside.		
	He had forgotten to	o sign the 11:00 a.m. dose off			Corrective actions to be		
	on the medication	administration record which			monitored to ensure the		
	made it appear as i	f the medication had not been			deficient practice will not		
	given. QMA 5 ind	icated it was not policy to leave			recur:		
	medications at the	bedside.			The Director of Nursing/Unit		
					Manager/Designee will comple	ete a	
	On 1/7/22 at 1:19	p.m., the Regional Director of			medication administration		
	Clinical Operation	s provided a current copy of the			observation for 3 residents a w	veek	
	document titled "N	Iedication Administration"			x 4 weeks, then 2 residents a		
	dated 12/14/17. It	included, but was not limited to,			week x 4 weeks, then 1 reside	nt	
	"PolicyIt is the p	olicy of this facility to provide			with a week for 4 weeks to ens	sure	
	resident centered c	areProcedureRemain with			medications are observed to b	е	
	the resident until the	ne medication is			taken at time of administration	and	
	swallowedMedic	cations will be charted when			not left at the bedside. This w	ill	
	given"				occur for no less than 3 month	IS	
					and compliance is maintained.		
	This Federal tag re	lates to Complaint IN00369787			The DON/Designee will preser	nt	
					the results of these audits mor	nthly	
	3.1-45(a)(2)				to the QAPI committee for no I	ess	
					than 3 months. Any patterns t	hat	
					are identified will have an Action		
					Plan initiated. The QAPI		

STATEMENT	Γ OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155659	B. WING		01/07/2022
NAME OF PR	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	
				DLD HWY # 60	
SELLERS	BURG HEALTHC	ARE CENTER	SELLE	RSBURG, IN 47172	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLET
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				committee will determine when	
				100% compliance is achieved	
				ongoing monitoring is required <b>F 690 Bowel/Bladder</b>	i.
				Incontinence, Catheter, UTI	
				Corrective action for the	
				residents found to have beer	n
				affected by the deficient	
				practice:	
				Resident D was identified as b	-
				affected by the deficient practi	
				Resident K was identified as b	-
				affected by the deficient practi	ce.
				Corrective action taken for	
				those residents having the	
				potential to be affected by th same deficient practice:	e
				All residents with foley cathete	ers
				have the potential to be affected	
				by the deficient practice.	
				An audit of the last 30 days for	r 🛛
				residents having foley cathete	rs
				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	<b>P</b>
				deficient practice does not	
				recur:	
				The Administrator/DON/Desig	nee
				held an in-service for nursing	staff
				to provide education and	
				expectations as it relates to the	e
				"Catheter Care" and	
				documentation of catheter out	put
				per physician order Corrective actions to be	

	R MEDICARE & MEDIC					MB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155659	(X2) MULTIPI A. BUILDIN B. WING	le construction Ig <u>00</u>	COMI	(X3) DATE SURVEY COMPLETED 01/07/2022	
	PROVIDER OR SUPPLIE		782	EET ADDRESS, CITY, STATE, ZIP 23 OLD HWY # 60 LLERSBURG, IN 47172	COD		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	DRRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
				monitored to ensure deficient practice will recur: The DON/Unit Manag will audit 3 residents of catheters a week x 4 2 residents with cather x 4 weeks, then 1 res catheter a week for 4 ensure documentation output has been comp physician orders on th will occur for no less to months and complian maintained. The DON/Designee withe results of these autor to the QAPI committee than 3 months. Any p are identified will have Plan initiated. The QAPI committee will determ 100% compliance is a ongoing monitoring is	II not ger/Designee with weeks, then eters a week ident with a weeks to n of catheter pleted per ne TAR. This than 3 ce is will present udits monthly e for no less patterns that e an Action API nine when achieved or if		
F 0690 SS=E Bldg. 00	§483.25(e) Incon §483.25(e)(1) Th resident who is co bowel on admissi assistance to ma or her clinical cor that continence is §483.25(e)(2)For incontinence, bas	continence, Catheter, UTI tinence. e facility must ensure that ontinent of bladder and on receives services and ntain continence unless his dition is or becomes such not possible to maintain. a resident with urinary ed on the resident's ssessment, the facility must					

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155659	(x2) multiple construction a. building <u>00</u> b. wing			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 01/07/2022	
	PROVIDER OR SUPPLIE			7823 OL	DDRESS, CITY, STATE, ZIP COD D HWY # 60 SBURG, IN 47172		
X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	<ul> <li>(i) A resident who an indwelling cath unless the resider demonstrates tha necessary;</li> <li>(ii) A resident who indwelling cathete one is assessed f as soon as possib clinical condition of catheterization is</li> <li>(iii) A resident wh receives appropri to prevent urinary restore continence</li> <li>§483.25(e)(3) For incontinence, bas comprehensive at ensure that a resi bowel receives ap services to restore function as possib Based on observati review, the facility catheter care was c monitored catheter physician, for 4 of Indwelling Foley cf G)</li> <li>Findings include:</li> <li>1. The clinical reco on 1/5/22 at 1:54 p not limited to, stage The care plan, date</li> </ul>	enters the facility without neter is not catheterized nt's clinical condition t catheterization was o enters the facility with an er or subsequently receives or removal of the catheter ole unless the resident's demonstrates that necessary; and o is incontinent of bladder ate treatment and services tract infections and to e to the extent possible. The a resident with fecal ed on the resident's assessment, the facility must dent who is incontinent of opropriate treatment and e as much normal bowel ole. on, interview, and record failed to ensure Indwelling ompleted and to ensure staff output, as ordered by the 4 residents reviewed for atheters. (Residents C, E, F, and rd for Resident C was reviewed m. Diagnosis included, but was e 4 sacral pressure ulcer. d 9/8/21, indicated the resident Foley catheter and to provide	F 06	90	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 be affected by the deficient practic Resident E was identified as be affected by the deficient practic Resident F was identified as be affected by the deficient practic Resident F was identified as be affected by the deficient practic Resident F was identified as be affected by the deficient practic Resident G was identified as be affected by the deficient practic Resident G was identified as be affected by the deficient practic Resident G was identified as be affected by the deficient practic Resident G was identified as be affected by the deficient practic	eing ce. eing ce. eing ce. eing	02/07/2022

PRINTED: 02/28/2022 FORM APPROVED

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155659		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u>			COMPLETED		
			B. WIN		00	01/07	
		100000	D			01/01/	
NAME OF	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP COD		
SELLERSBURG HEALTHCARE CENTER					LD HWY # 60		
DELLER		ARE CENTER		SELLE	RSBURG, IN 47172		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	Р	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					potential to be affected by th	e	
		21 MAR (medication			same deficient practice:		
	administration rec	ord) indicated the following:			All residents with foley cathete		
					have the potential to be affected	ed	
	-Cleanse the Indw			by the deficient practice.	_		
	and water every sh			An audit of the last 30 days for			
	-Measure and reco			residents having foley catheter			
	The aliminal magnet			has been completed to ensure			
	The clinical record catheter care and t			foley catheter output has been			
				completed as ordered by the			
	011 12/ 9/ 21 and 12/	/14/21 during the day shift.			physician.		
	The January 2022	MAR indicated to cleanse the			Any identified concerns were immediately addressed.		
		theter with soap and water			Measures/systemic changes	nut	
		measure/record urine output.			into place to ensure the	put	
	every shift and to	measure/record unite output.			deficient practice does not		
	The clinical record	l lacked documentation of Foley			recur:		
		he measurement of urine output			The Administrator/Director of		
	between $1/1/22$ an				Nursing/Designee held an		
					in-service for nursing staff to		
	During an intervie	w on 1/7/22 at 11:13 a.m., LPN			provide education and		
		l Nurse) 3 indicated once care			expectations as it relates to the	e	
		f would sign off on the			"Catheter Care" and		
	-	o show care was completed.			documentation of catheter out	put	
				per physician order.			
	2. The clinical rec			Corrective actions to be			
	on 1/6/22 at 9:35 a			monitored to ensure the			
	not limited to, acu			deficient practice will not			
					recur:		
	· ·	ed 2/5/20, indicated the resident			The DON/Unit Manager/Desig	nee	
	-	suprapubic catheter and to			will audit 3 residents with		
	monitor output.				catheters a week x 4 weeks, th		
					2 residents with catheters a we		
		21 and January 2022 treatment			x 4 weeks, then 1 resident with		
		ord indicated to cleanse the			catheter a week for 4 weeks to		
	-	and water every shift and to			ensure documentation of cathe		
	measure/record ou	ttput every shift.			output has been completed pe		
					physician orders. This will occ	cur	
	The clinical record			for no less than 3 months and			
	and the measurem	ent of urine output was not			compliance is maintained.		

Event ID: 0GEE11 Facility ID: 010613

If continuation sheet Page 14 of 20

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 01/07/2022 155659 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7823 OLD HWY # 60 SELLERSBURG HEALTHCARE CENTER SELLERSBURG, IN 47172 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE completed for day shift on 12/9/21, 12/14/21, The DON/Designee will present 12/16/21, 12/22/21 through 12/24/21, and 12/30/21; the results of these audits monthly catheter cleansing for night shift was not to the QAPI committee for no less completed on 12/31/21, 1/1/22, and 1/3/22; and than 3 months. Any patterns that urine output was not documented for night shift are identified will have an Action on 12/20/21, 12/30/21, 12/31/21, 1/1/22, 1/2/22, and Plan initiated. The QAPI 1/3/22.committee will determine when 100% compliance is achieved or if 3. The clinical record for Resident F was reviewed ongoing monitoring is required. 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 Event ID: 0GEE11 Facility ID: 010613 Page 15 of 20 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

02/28/2022

PRINTED:

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		x1) provider/supplier/clia identification number 155659	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 01/07/2022	
	PROVIDER OR SUPPLI		7823 (	f address, city, state, zip cod OLD HWY # 60 ERSBURG, IN 47172		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL DR 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 0695 SS=D Bldg. 00	measure/record of The January 2022 documentation of output and for cat On 1/7/22 at 1:19 Clinical Operation document titled "v included, but was policy of this faci careCatheter cat daily on residents catheters" This Federal tag r and IN00370341. 483.25(i) Respiratory/Trac Suctioning § 483.25(i) Resp tracheostomy cat is provided such professional stat comprehensive the residents' go 483.65 of this su Based on intervie failed to ensure an a resident (Reside	treatment administration lacked the measurement of urine heter care on 1/4/22 and 1/5/22. p.m., the Regional Director of as provided a current copy of the Catheter Care" dated 5/1/2017. It not limited to, "PolicyIt is the lity to provide resident re is performed at least twice that have indwelling elates to Complaints IN00369787 cheostomy Care and biratory care, including are and tracheal suctioning. ensure that a resident who y care, including are and tracheal suctioning, care, consistent with ndards of practice, the person-centered care plan, wals and preferences, and	F 0695	F695 Respiratory/Tracheostom Care and Suctioning Corrective action for the residents found to have been	vy 02/07/202	
	respiratory care. Findings include:			affected by the deficient practice: Resident F was identified as bei affected by the deficient practice	-	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 01/07/2022 155659 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7823 OLD HWY # 60 SELLERSBURG HEALTHCARE CENTER SELLERSBURG, IN 47172 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE The clinical record for Resident F was reviewed on Corrective action taken for 1/6/22 at 10:08 a.m. Diagnosis included, but was those residents having the not limited to, bronchitis (inflammation of the potential to be affected by the bronchial tubes). same deficient practice: All residents requiring an antibiotic The physician's order, dated 12/23/21 at 6:27 a.m., have the potential to be affected indicated the resident was to receive by the deficient practice. Amoxicillin-Potassium Clavulanate (antibiotic for A 30 day look back of antibiotic bacterial infection) 875-125 mg (milligrams), one orders has been completed to tablet every 12 hours for bronchitis at 8:00 a.m. ensure administration was and 8:00 p.m. completed as ordered by the physician. Any identified The care plan, dated 12/23/21, indicated the concerns were immediately resident had bronchitis and to administer addressed. antibiotics per medical provider's orders. Measures/systemic changes put into place to ensure the The December 2021 medication administration deficient practice does not record indicated the medication was not recur: administered on 12/23/21 at 8:00 a.m., 12/24/21 at The Administrator/Director of 8:00 a.m., and 12/28/21 at 8:00 p.m. Nursing/Unit Manager/Designee held an in-service for licensed During an interview on 1/7/22 at 11:13 a.m., LPN nursing staff to provide education (Licensed Practical Nurse) 3 indicated the and expectations as it relates to medication administration record should be "Medication Administration" with signed off to show the medication was focus on antibiotics administered administered. as ordered by the physician. Corrective actions to be On 1/7/22 at 1:19 p.m., the Regional Director of monitored to ensure the Clinical Operations provided a current copy of the deficient practice will not document titled "Medication Administration" recur: dated 12/14/17. It included, but was not limited to, The Director of Nursing/Unit "Medication Administration Record - the legal Manager/Designee will audit documentation for medication residents requiring an antibiotic to administration...Policy...It is the policy of this ensure administration has been facility to provide resident centered completed as ordered by the care...Medications will be charted when given...." physician as follows: 5 residents a week x 4 weeks, then 3 residents This Federal tag relates to Complaint IN00370341 a week x 4 weeks. then 1 resident a week for 4 weeks for no less 3.1-47(a)(6) than 3 months and compliance is

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0GEE11 Facility

Facility ID: 010613

If continuation sheet

Page 17 of 20

02/28/2022

PRINTED:

		CAID SERVICES				1B NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155659		(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING		(X3) DATE SURVEY COMPLETED 01/07/2022		
	PROVIDER OR SUPPLIE SBURG HEALTHC		7823	f address, city, state, zip cod OLD HWY # 60 ERSBURG, IN 47172	1	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
				concerns will be immediately addressed. The DON/Unit Manager/Desi- will present the results of thes audits monthly to the QAPI committee for no less than 3 months. Any patterns that ar identified will have an Action initiated. The QAPI committee determine when 100% compl is achieved or if ongoing monitoring is required.	e Plan e will	
= 0760 SS=D Bldg. 00	The facility must §483.45(f)(2) Res significant medica Based on interview failed to ensure med ordered (Resident orders were impler C) for 2 of 3 reside medication errors. Findings include: 1. The clinical rec on 1/5/22 at 1:21 p not limited to, left thrombosis. The care plan, date resident had a deep lower extremity an	sidents are free of any	F 0760	F 760 Residents are Free of Significant Med Errors Corrective action for the residents found to have bee affected by the deficient practice: Resident B was identified as affected by the deficient pract Resident C was identified as affected by the deficient pract Corrective action taken for those residents having the potential to be affected by th same deficient practice: Any resident a procedure req pre-op orders has the potenti be affected by the deficient practice. A 30 day look back has been	being tice. being tice. <b>he</b> uiring al to	02/07/202

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	T OF HEALTH AND HU R MEDICARE & MEDIC						ORM APPROVED MB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION		ESURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMP	LETED
	155659		B. WI	B. WING			7/2022
NAMEOFI		D		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF 1	NAME OF PROVIDER OR SUPPLIER			7823 OLD HWY # 60			
SELLER	SBURG HEALTHC	ARE CENTER		SELLE	RSBURG, IN 47172		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	resident was to rec	eive Apixaban (blood thinner) 5			who have had a procedure to		
	mg (milligrams) tw	vice daily.			ensure pre-op orders were		
					implemented. Any identified		
	The clinical record	lacked documentation of the			concerns were immediately		
	administration of the	he medication for evening shift			addressed.		
	on 12/9/21, 12/10/2	21, 12/13/21, 12/14/21, 12/18/21,			Measures/systemic changes	s put	
	12/19/21, 12/23/21, and 12/24/21.				into place to ensure the	•	
					deficient practice does not		
	During an interview	w on 1/7/22 at 11:13 a.m., LPN			recur:		
	e	l Nurse) 3 indicated the			The Administrator/Director of		
		stration record should be			Nursing/Unit Manager/Desigr	nee	
	signed off to show	the medication was			held an in-service with license		
	administered.				nursing staff to provide educa		
					and expectations as it relates		
	2 The clinical rec	ord for Resident C was reviewed			"Medication Administration" w		
		.m. Diagnoses included, but			focus on implementation of P		
		, peripheral vascular disease			orders.	ic-op	
	and atrial fibrillation				Corrective actions to be		
					monitored to ensure the		
	The progress note	dated 9/22/21 at 3:07 p.m.,			deficient practice will not		
		con's office had called with			recur:		
	-	rs given and verified per the			The Administrator/Director of		
		The resident was scheduled for			Nursing/Unit Manager/Desigr		
	surgery on 10/5/21				will audit residents requiring p		
	surgery on 10/5/21				order implementation for	ne ob	
	Review of the pre-	op orders report, dated 9/28/21,			-	lonte	
	-	ent's apixaban (eliquis) 5 mg			completion as follows: 3 resid a week x 4 weeks, then 2		
					-	han	
		opped 3 days prior to the			residents a week x 4 weeks, t		
	procedure.				1 resident a week for 4 week	SIOF	
		-1 2021 diati			no less than 3 months and		
		ober 2021 medication			compliance is maintained. A	ту	
		ord indicated the medication			identified concerns will be		
	was not stopped as	ordered.			immediately addressed.		
					The Director of Nursing/Unit		

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0GEE11

Facility ID: 010613

If continuation sheet

Manager/Designee will present the

results of these audits monthly to

than 3 months. Any patterns that

are identified will have an Action

Plan initiated. The QAPI

the QAPI committee for no less

Page 19 of 20

PRINTED: 02/28/2022 FORM APPROVED

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155659	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 01/07/2022			
NAME OF PROVIDER OR SUPPLIER SELLERSBURG HEALTHCARE CENTER			7823	STREET ADDRESS, CITY, STATE, ZIP COD 7823 OLD HWY # 60 SELLERSBURG, IN 47172				
(X4) ID PREFIX TAG	(EACH DEFICIE	SUMMARY STATEMENT OF DEFICIENCIE EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE TAG DEFICIENCY)		(X5) COMPLETION DATE		
	Clinical Operation document titled "M dated 12/14/17. It "Medication Admin documentation for administrationPc facility to provide careMedications On 1/7/22 at 1:19 p Clinical Operation document titled "P It included, but was the policy of this f centered careExe takes the physician executing the orde orders"	olicyIt is the policy of this		committee will determi 100% compliance is a ongoing monitoring is	chieved or if			

0GEE11 Facility ID: 010613

10613 If continuat

If continuation sheet Page 20 of 20