STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155659	B. WI	B. WING		09/24/	2021
		10000				00/2 1/	2021
NAME OF F	PROVIDER OR SUPPLIEF	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
	NO VIDEN ON BOTTELL			7823 O	LD HWY # 60		
SELLERS	SBURG HEALTHC	ARE CENTER		SELLE	RSBURG, IN 47172		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00							
	This visit was for It	nvestigation of Complaints	F 00	000	Preparation or execution of t	his	
		362077, IN00362236,	1 00	<i>,</i>	plan of correction does not		
	· ·	362699, IN00362714,			constitute admission or		
	· ·						
	· ·	363091 and a COVID-19			agreement of provider of the		
	Focused Infection (	Control Survey.			truth of the facts alleged or		
	G 11 . D. 2000				conclusions set forth on the		
	*	1266 - Substantiated.			State of Deficiencies. The Pla		
		encies related to the			of Correction is prepared and		
	allegations are cited	d at F677 and F725.			executed solely because it is	i	
					required by the position of		
	*	2077 - Substantiated.			Federal and State Law.		
	Federal/State defici	encies related to the			The Plan of Correction is		
	allegations are cited	d at F759 and F776.			submitted in order to respon	d	
					to the allegation of		
	Complaint IN00362	2236 - Substantiated.			noncompliance cited during	the	
	Federal/State defici	encies related to the			complaint survey conducted	on	
	allegations are cited	d at F686, F690, F691, and			September 21, 22, 23, and 24	,	
	F725.				2021.		
					Please accept this plan of		
	Complaint IN00362	2293 - Substantiated. No			correction as the provider's		
	*	to the allegations are cited.			credible allegation of		
		5			compliance.		
	Complaint IN00362	2699 - Unsubstantiated due			The facility would like to		
	to lack of sufficient				respectfully request a desk		
	, , , , , , , , , , , , , , , , , , ,	,			review.		
	Complaint IN00363	2714 - Unsubstantiated due to			Monica Dirbas, LNHA		
	lack of sufficient ev				mornou Birbuo, Errina		
	luck of Sufficient C	ridefice.					
	Complaint IN0036	2911 - Substantiated.					
	-	encies related to the					
	allegations are cited	1 at FO / / and F / 23.					
	C1-: ( DI0026	2001 Sub-tantist					
	-	3091 - Substantiated.					
		ency related to the allegation					
	is cited at F725.						
	Survey dates: Sept	ember 21, 22, 23, and 24,					

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155659	B. WING		09/24/2021
	PROVIDER OR SUPPLIER		7823 (	ADDRESS, CITY, STATE, ZIP CODE DLD HWY # 60 ERSBURG, IN 47172	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	2021				
	Facility number: 01				
	Provider number: 1 AIM number: 2002				
	Anvi number: 2002	.21040			
	Census Bed Type:				
	SNF/NF: 93				
	Total: 93				
	C D T				
	Census Payor Type: Medicare: 14	:			
	Medicaid: 63				
	Other: 16				
	Total: 93				
		reflect State Findings cited in			
	accordance with 410	0 IAC 16.2-3.1.			
	Quality review com	pleted on October 1, 2021.			
	Quality Teview com	proceed on October 1, 2021.			
F 0677	483.24(a)(2)				
SS=D		d for Dependent Residents			
Bldg. 00	- ' ' ' '	esident who is unable to			
		of daily living receives the			
		s to maintain good			
	hygiene;	g, and personal and oral			
		and record review, the	F 0677	F 677 ADL Care provided to	10/20/2021
		ure residents were bathed	1 00//	Dependent Residents	10/20/2021
	•	e for 3 of 5 residents		'	
	reviewed for Activi			Corrective action for the residence	ents
	(Residents B, D, and	d K)		found to have been affected b	у
				the deficient practice:	
	Findings include:			Desident Day 11 (15)	
	1. The elimination	d for Docident D v		Resident B was identified as b	-
		rd for Resident B was 1 at 12:09 p.m. Diagnoses		affected by the deficient practi	Ce.
		not limited to, left-sided		Resident D was identified as	
		is of one side of the body),		being affected by the deficient	
		is at one side of the oddy),		and an action by the deficient	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	UILDING	00	COMPI	LETED
		155659	B. W	ING		09/24	/2021
					- DDDDDD COMMAN AT 1 TO THE AT	33,21	· ·
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
					LD HWY # 60		
SELLERS	SBURG HEALTHC	ARE CENTER		SELLE	RSBURG, IN 47172		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	hypertension, and a	atrial fibrillation.			practice.		
	_	d 7/26/21, indicated the			Resident K was identified as		
	resident had a self-care deficit and preferred his				affected by the deficient prac	ctice.	
	showers every Mor	nday and Thursday night.					
					Corrective action taken for the		
		lents bathing schedule lacked			residents having the potentia		
		shower on 9/2/21 (Thursday)			be affected by the same defi-	cient	
	and 9/9/21 (Thursd	ay)			practice:		
	During an interview	w on 9/24/21 at 11:27 a.m., the			All residents have the potent	ial to	
		g indicated staff should be			be affected by the deficient	iai to	
	following the resid				practice.		
	Tonowing the resid	ents plan of care.			process.		
	2. The clinical reco	ord for Resident D was			An audit of shower/bathing for	or all	
	reviewed on 9/21/2	11 at 3:24 p.m. Diagnoses			residents has been complete	ed to	
	included, but were	not limited to, hypertension			ensure a minimum of 2		
	and colostomy.				shower/bathing days have be	een	
					scheduled per the residents	plan	
	The care plan, date	d 10/6/20, indicated the			of care and preference.		
	resident had a self-	care deficit, required physical					
	assistance of one st	aff, and preferred to have her			Any identified concerns have	;	
	showers on Tuesda	y and Thursday.			been immediately addressed	l.	
	Review of the show	ver records indicated the			Measures/systemic changes	nut	
		bed bath on 8/24/21 and			into place to ensure the defic	-	
	8/31/21.	oca oath on 6/2 //21 and			practice does not recur:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
					p. 2000 4000 Hot 10001.		
	The clinical record	lacked documentation of the			The Administrator/DON/Desi	gnee	
	residents refusal of	a shower on 8/24/21 and			held an in-service for nursing	•	
	8/31/21.				direct care staff to provide		
					education and expectations a	as it	
	3. The clinical reco	ord for Resident K was			relates to "Personal Bathing	and	
	reviewed on 9/22/2	21 at 12:19 p.m. Diagnoses			Shower" policy to include		
	included, but were	not limited to, quadriplegia			shower/bathing schedules,		
	(paralysis) and saci	ral region pressure ulcer.			following the plan of care for		
					bathing and honoring resider	nt	
	The care plan, date	d 1/28/21, indicated the			bathing preferences.		
	resident had a self-	care deficit, required staff					
	assistance with bat	hing, and preferred her			Corrective actions to be		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLI	ETED
		155659	B. W	ING	<del></del>	09/24/2	2021
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
051150		ADE OFNITED			LD HWY # 60		
SELLERS	SBURG HEALTHCA	ARE CENTER		SELLER	RSBURG, IN 47172		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	Ī	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	showers on Wednes	day and Sunday on day shift.			monitored to ensure the deficie	ent	
					practice will not recur:		
	Review of the bathi	ng records indicated the					
	resident received a l	ped bath on 9/1/21.			The DON/Unit Manager/Desig	nee	
					will audit showers/bathing		
	The clinical record	lacked documentation of the			schedule, bathing care plan ar	nd	
	resident refusal of a	shower.			resident bathing preference for	r 2	
					residents 3 days a week x 4		
	During an interview	on 9/23/21 at 1:41 p.m., the			weeks, then 2 residents 2 days	sa	
	resident indicated sl	ne preferred showers but was			week x 4 weeks, then 2 reside	nt a	
	given bed baths dur	ing the outbreak because they			week for 4 weeks for no less th	nan	
	were told they could	d not go out of their rooms.			3 months and compliance is		
					maintained.		
	On 9/24/21 at 10:48	a.m., the Director of					
	Nursing provided a	current copy of the document			Any identified concerns will be		
	titled "Personal Batl	hing and Shower" dated			immediately addressed.		
	5/2003. It included,	but was not limited to, "It is					
	the policy of this fac	cility to provide resident			The DON/Designee will preser	nt	
	centered careResid	dents have the right to			the results of these audits mor	nthly	
	choose their schedu	les"			to the QAPI committee for no I	ess	
					than 3 months. Any patterns t	hat	
	This Federal tag rela	ates to Complaints			are identified will have an Action	on	
	IN00361266 and IN	00362911			Plan initiated. The QAPI		
					committee will determine wher		
	3.1-38(a)(2)				100% compliance is achieved	or	
					if ongoing monitoring is require	ed.	
F 0686	483.25(b)(1)(i)(ii)						
SS=E	-	Prevent/Heal Pressure					
Bldg. 00	Ulcer						
	§483.25(b) Skin In						
	§483.25(b)(1) Pres						
		prehensive assessment of					
	· ·	ility must ensure that-					
	` '	ves care, consistent with					
		ards of practice, to prevent					
		nd does not develop					
	pressure ulcers ur	less the individual's clinical					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155659	B. W	ING		09/24/	/2021
				CENTER	A DDDDGG GUTY GTATE JUD GODE		
NAME OF P	ROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
					LD HWY # 60		
SELLERS	SELLERSBURG HEALTHCARE CENTER			SELLE	RSBURG, IN 47172		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	16	DATE
	condition demons	trates that they were					
	unavoidable; and	•					
	(ii) A resident with	pressure ulcers receives					
	necessary treatme	ent and services, consistent					
	with professional	standards of practice, to					
	promote healing,	prevent infection and					
	prevent new ulcer	s from developing.					
	Based on interview	and record review, the	F 00	586			10/20/2021
	facility failed to ens	sure wound treatments were			F 686 Treatment/Svcs to		
	completed, as order	red by the physician, for 4 of			Prevent/Heal Pressure Ulcer		
	4 residents reviewe	d for pressure ulcers.			Corrective action for the		
	(Residents D, K, L,	and M)			residents found to have beer	า	
					affected by the deficient		
	Findings include:				practice:		
					Resident D was identified as		
	1. The clinical reco	rd for Resident D was			being affected by the deficient		
		1 at 3:24 p.m. Diagnosis			practice.		
		ot limited to, stage 4 pressure			Resident K was identified as b	-	
	`	tends below the subcutaneous			affected by the deficient practi		
		ssues like muscle, tendons,			Resident L was identified as b	•	
	- '	ne sacral region. The quarterly			affected by the deficient practi	ce.	
	· ·	ata Set) assessment, dated			Resident M was identified as		
	8/10/21, indicated to	he resident's cognition was			being affected by the deficient		
	intact.				practice.		
					Corrective action taken for		
	-	d 10/6/20, indicated the			those residents having the		
		for pain due to a stage 4			potential to be affected by th	е	
	•	e coccyx and to complete			same deficient practice:		
	dressing changes as	s ordered.			All residents at risk for or who		
	and the				currently have wound treatmen		
		ion report, dated 9/16/21,			have the potential to be affected	ea	
		nt had a stage 4 pressure			by the deficient practice.		
	-	x which measured 0.77 cm			An audit of last 30 days for	haan	
		gth, .67 cm in width with a			residents having wounds has I		
	depth of .10 cm.				completed for review of treatm	EIIL	
	The physician's1	or dated 9/2/21 indicated to			completion as ordered by the		
		er, dated 8/3/21, indicated to			physician.		
	- '	pressure ulcer with normal			Measures/systemic changes		
		apply skin prep (provides a			put into place to ensure the		
	protective film) to t	the periwound bed. Apply			deficient practice does not		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED
		155659	B. W	ING		09/24/2021
		10000				33/2 1/232 1
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
TO HAVE OF T	NO VIDER OR SOLVEIL			7823 O	LD HWY # 60	
SELLERS	SBURG HEALTHCA	ARE CENTER		SELLER	RSBURG, IN 47172	
(VA) ID	CHMMADN C	TATEMENT OF DEFICIENCIES	1	ID		(7/5)
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		used for wound healing) into			recur:	
	the wound bed, use	an ABD (abdominal) pad to			The Administrator/DON/Desig	nee
	fill the void between	n the buttocks, and cover with			held an in-service for nursing s	staff
	border foam every o	lay shift.			to provide education and	
					expectations as it relates to the	e
	Review of the Augu	st 2021 and September 2021			"Monitoring a Wound" and	
	_	ation record indicated the			documentation of treatment	
		ompleted on 8/12/21,			completion on the TAR.	
	8/20/21, 8/27/21, 8/	-			Corrective actions to be	
	0/20/21, 0/2//21, 0/	30/21, und 9/3/21.			monitored to ensure the	
	The physician's ard	er, dated 9/14/21, indicated to			deficient practice will not rec	ur.
		wound with normal saline, pat			The DON/Wound Nurse/Desig	
		-			<u> </u>	
		to the wound bed, and cover			will audit 2 residents with wour	
	with a border foam	dressing daily.			3 days a week x 4 weeks, ther	12
					residents 2 days a week x 4	
	_	1 treatment administration			weeks, then 1 resident a week	
	record indicated the				4 weeks to ensure the complet	tion
	completed on 9/17/2	21 and 9/21/21.			of the treatment per physician	
					orders on the TAR. This will	
	During an interview	on 9/22/21 at 3:18 p.m.,, RN			occur for no less than 3 month	s
	3 indicated when a	treatment was completed, the			and compliance is maintained.	
	treatment administra	ation record should be signed			The DON/Wound Nurse/Desig	nee
	by whomever comp	leted the treatment.			will present the results of these	e
	_				audits monthly to the QAPI	
	2. The clinical recor	rd for Resident K was			committee for no less than 3	
		1 at 12:19 p.m. Diagnosis			months. Any patterns that are	
		ot limited to, sacral region			identified will have an Action P	
	pressure ulcer.				initiated. The QAPI committee	
	pressure uncer.				determine when 100% complia	
	The care plan dated	1 4/27/21, indicated the			is achieved or if ongoing	
		ed skin integrity and to			monitoring is required.	
		ts as ordered by the medical			i monitoring is required.	
		is as ordered by the medical				
	provider.					
		1 1 10/1/01				
		on report, dated 9/16/21,				
		nt had a stage 4 sacral wound				
		9 cm in length, 4.54 cm in				
	width with a depth of	of 3 cm.				
	The physician's orde	er, dated 8/3/21, indicated to				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			JILDING	00	(X3) DATE COMPL		
		155659	B. W	ING		09/24/	2021
	PROVIDER OR SUPPLIER		•	7823 OL	DDRESS, CITY, STATE, ZIP CODE  D HWY # 60		
	SBURG HEALTHCA	ARE CENTER		SELLER	RSBURG, IN 47172		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSG IDENTIFYING DEFORMATIONS		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛΤΕ	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION) with wound cleanser, pat dry,	_	TAG	DEFICIENCY		DATE
		ormal saline wet to dry and					
	The August 2021 tr record indicated the completed on 8/5/2						
	cleanse the wound	er, dated 8/12/21, indicated to with Dakin's (used to debride ack with silver alginate and design every shift.					
	The August 2021 at administration indic	and September 2021 treatment stated the treatment was not allowing dates and shifts:  Output  Output  Description:					
	cleanse the wound v place a Dakin's moi wound bed and cov dressing twice daily						
	The September 202 record indicated the completed on 9/17/2						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155659	(X2) MULTIP A. BUILDIN B. WING		NSTRUCTION  00	(X3) DATE COMPL 09/24/	ETED
	PROVIDER OR SUPPLIER		782	23 OL	DDRESS, CITY, STATE, ZIP CODE D HWY # 60 SBURG, IN 47172		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛΤΕ	(X5) COMPLETION DATE
	reviewed on 9/22/2	rd for Resident L was 1 at 1:14 p.m. Diagnosis ot limited to, stage 4 pressure ium.					
	_	1 2/23/21, indicated the ure ulcer and to provide tment order.					
	indicated the reside	on report, dated 9/16/21, nt had a stage 4 pressure ium which measured .44 cm width with a depth of .30 cm.					
	cleanse the left isch	er, dated 8/12/21, indicated to ium with wound cleanser, pat alginate and cover with a foam and night shift.					
	administration reco	nd September 2021 treatment rd indicated the treatment on the following dates and					
	-8/13/21 - day shift -8/17/21 - day shift -9/03/21 - night shift -9/04/21 - day shift -9/11/21 - day shift -9/15/21 - day shift -9/16/21 - day shift -9/17/21 - night shift -9/18/21 - day shift -9/19/21 - day shift	it					
	reviewed on 9/22/2	rd for Resident M was 1 at 1:30 p.m. Diagnosis of limited to, unstageable e coccyx.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155659	B. W	ING		09/24/	2021
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			LD HWY # 60		
SELLER!	SBURG HEALTHC	ARE CENTER			RSBURG, IN 47172		
				OLLLLI			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	d 5/11/21, indicated the					
	_	risk for pressure ulcers and					
	to provide skin care	e per facility guidelines.					
		ion report, dated 9/16/21,					
		ent had an unstageable					
	1 ^	e coccyx which measured 4.6					
	I -	em in width with a depth of					
	0.2 cm.						
	m 1 · · · 1	1 . 10/11/01 . 1					
		ler, dated 8/11/21, indicated to					
		with normal saline, pat dry,					
		the wound and cover with a					
	dry dressing every	shift.					
	Davious of the Aug	ust 2021 and September 2021					
	_	ration record indicated the					
		completed on the following					
	dates and shifts:	completed on the following					
	dates and sinits.						
	-8/16/21 - day or ni	oht shift					
	-8/17/21 - night shi	_					
	-8/18/21 - day shift						
	-8/19/21 - day shift						
	-8/23/21 - night shi						
	-8/24/21 - day shift						
	-9/01/21 - day shift						
	-9/02/21 - day shift						
	-9/05/21 - day shift						
	-9/07/21 - day shift						
	-9/08/21 - day shift						
	-9/13/21 - day shift						
	-						
	The physician's ord	ler, dated 9/14/21, indicated to					
	cleanse the coccyx	with wound cleanser, pat dry,					
	apply medihoney to	the wound bed and cover					
	with adhesive borde						
	The September 202	1 treatment administration					
	record indicated the	e treatment was on completed					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155659	r í	JILDING	NSTRUCTION  00	(X3) DATE COMPI <b>09/24</b>	LETED
	PROVIDER OR SUPPLIER SBURG HEALTHCA			7823 OL	DDRESS, CITY, STATE, ZIP CODE LD HWY # 60 RSBURG, IN 47172		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
F 0690 SS=D Bldg. 00	A current copy of the "Monitoring A Would but was not limited resident/patient is end admissionProcedut treatments as ordered tre	and" dated 7/1/16, included, to, "PolicyEach valuated upon areImplement wound and.  Interest to Complaint  ontinence, Catheter, UTI nence.  facility must ensure that not not possible to maintain.  Interest to maintain.  Int					

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Event ID:

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Facility ID: 010613

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155659	B. W	NG		09/24/	2021
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
051155		ADE OFWEED			LD HWY # 60		
SELLER	SBURG HEALTHCA	ARE CENTER		SELLER	RSBURG, IN 47172		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF C			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
	receives appropria	ate treatment and services					
	to prevent urinary	tract infections and to					
		e to the extent possible.					
	§483.25(e)(3) For	a resident with fecal					
	_ ,,,,	ed on the resident's					
		sessment, the facility must					
	•	dent who is incontinent of					
		propriate treatment and					
		e as much normal bowel					
	function as possib						
		and record review, the	F 00	500	F 690 Bowel/Bladder		10/20/2021
		sure Foley catheter care was	1 00	) <del>9</del> 0	Incontinence, Catheter, UTI		10/20/2021
	•	ed by the physician, for 2 of			Corrective action for the		
	_	d for Indwelling catheters.			residents found to have beer		
		<del>-</del>				ı	
	(Resident D and K)				affected by the deficient		
	Findings in dede				practice:		
	Findings include:				Resident D was identified as		
	1 The dialog				being affected by the deficient		
		ord for Resident D was			practice.	oina	
		1 at 3:24 p.m. Diagnosis			Resident K was identified as b	-	
		ot limited to, stage 4 pressure			affected by the deficient practi	ce.	
	ulcer of the sacral re	egion.			Corrective action taken for		
	The same of the state of	10/0/21 :- 1: - 4 - 14			those residents having the	_	
	-	1 9/8/21, indicated the			potential to be affected by the	E	
		(indwelling) catheter related			same deficient practice: All residents with foley cathete	ro	
	-	egrity and to provide catheter					
	care every shift.				have the potential to be affected	<del>z</del> u	
	The alerests: 1 1	on dotad 0/9/21 : 1: 1:			by the deficient practice.	_	
		er, dated 9/8/21, indicated to			An audit of the last 30 days for		
	_	neter with soap and water			residents having foley catheter		
	every shift.				has been completed to ensure	!	
	D 1 01 0	1 2021 TAP (:			foley catheter care has been		
	-	ember 2021 TAR (treatment			completed as ordered by the		
		rd) indicated the catheter			physician.		
	-	eted on 9/9/21 (night shift),			Any identified concerns were		
	9/16/21 (day shift),	or 9/17/21 (day shift).			immediately addressed.		
					Measures/systemic changes		
	-	on 9/22/21 at 3:18 p.m., RN			put into place to ensure the		
	3 indicated the TAR	R would be signed by the nurse			deficient practice does not		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
		155659	B. W	ING		09/24/20	21
				-			
NAME OF P	ROVIDER OR SUPPLIER	<b>t</b>		1	ADDRESS, CITY, STATE, ZIP CODE		
					LD HWY # 60		
SELLERS	SBURG HEALTHC	ARE CENTER		SELLER	RSBURG, IN 47172		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROVIDED'S DI AN OE CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	re C	OMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	to show care had be	een provided.			recur:		
					The Administrator/DON/Design	nee	
	2. The clinical reco	ord for Resident K was			held an in-service for nursing s	staff	
	reviewed on 9/22/2	1 at 12:19 p.m. Diagnoses			to provide education and		
	included, but were	not limited to, quadriplegia			expectations as it relates to the	e	
	(paralysis), neuroge	enic bladder, and sacral region			"Catheter Care" and		
	pressure ulcer.				documentation of care provide	d	
					per physician order on the TAI	₹.	
	The care plan, dated	d 1/18/21, indicated the			Corrective actions to be		
	resident had an indu	welling catheter and to provide			monitored to ensure the		
	catheter care every	shift.			deficient practice will not rec	ur:	
					The DON/Unit Manager/Desig	nee	
	The August 2021 at	nd September 2021 TAR			will audit 3 residents with		
	indicated to cleanse	the indwelling urinary			catheters a week x 4 weeks, the	nen	
	catheter every shift	with soap and water.			2 residents with catheters a we	eek	
					x 4 weeks, then 1 resident with	n a	
	The clinical record	lacked documentation of			catheter a week for 4 weeks to		
	catheter care of the	following dates and shifts:			ensure completion of catheter		
					care per physician orders on tl	ne	
	-8/19/21 - day shift				TAR. This will occur for no les	s	
	-8/23/21 - night shi	ft			than 3 months and compliance	is	
	-9/01/21 - day shift				maintained.		
	-9/02/21 - day shift				The DON/Designee will preser	nt	
	-9/05/21 - day shift				the results of these audits mor	nthly	
	-9/07/21 - day shift				to the QAPI committee for no I	ess	
	-9/08/21 - day shift				than 3 months. Any patterns t	hat	
	-9/13/21 - day shift				are identified will have an Action	on	
	-9/17/21 - day shift				Plan initiated. The QAPI		
					committee will determine wher		
		3 a.m., the Director of			100% compliance is achieved		
		current copy of the document			if ongoing monitoring is require	ed.	
		e" dated 10/13/2013. It					
		ot limited to, "PolicyIt is the					
		y to provide resident care					
		dsof the residents. Catheter					
		t least twice daily on					
		indwelling catheters, for as					
	long as the catheter	is in place"					
	This Federal tag rel	ates to Complaint					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. B	UILDING	00	COMPL	ETED
		155659	B. W	ING		09/24/	2021
	ROVIDER OR SUPPLIER		1	7823 O	ADDRESS, CITY, STATE, ZIP CODE LD HWY # 60 RSBURG, IN 47172		
			1		, I		(7/5)
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
	IN00362236						
	3.1-41(a)(2)						
F 0691	483.25(f)						
SS=D	` '	omy, or Ileostomy Care					
Bldg. 00	§483.25(f) Colosto						
Biag. 00	ileostomy care.	only, arestorny,, er					
		ensure that residents who					
		, urostomy, or ileostomy					
	-	such care consistent with					
		lards of practice, the					
		erson-centered care plan,					
		goals and preferences.					
		and record review, the	F 0	691	F 691 Colostomy, Urostomy,		10/20/2021
		ure colostomy care was	' '	071	Ileostomy Care		10/20/2021
	-	d by the physician, for 2 of 2			Corrective action for the		
	residents reviewed f				residents found to have beer	า	
	(Residents D and K)				affected by the deficient		
	,	,			practice:		
	Findings include:				Resident D was identified as		
	_				being affected by the deficient	-	
	1. The clinical reco	ord for Resident D was			practice.		
	reviewed on 9/21/21	1 at 3:24 p.m. Diagnosis			Resident K was identified as b	eing	
	included, but was no	ot limited to, colostomy			affected by the deficient practi	ce.	
	status.				Corrective action taken for		
					those residents having the		
		st 2021 and September 2021			potential to be affected by th	е	
	,	ninistration record) indicated			same deficient practice:		
		omy site was to be cleaned			All residents with colostomy ha		
	with soap and water	every shift.			the potential to be affected by	the	
					deficient practice.	ļ	
		nistration record for August			An audit of the last 30 days fo		
	_	r 2021 lacked documentation			residents having a colostomy	nas	
	_	n the following dates and			been completed to ensure		
	shifts:				colostomy care has been		
	0/10/01				completed as ordered by the	ļ	
	-8/12/21 - day shift				physician.	ļ	
	-8/20/21 - day shift				Any identified concerns were	ļ	
	-8/27/21 - day shift				immediately addressed.		

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X2)		X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING 00 COMPLETED			ETED
		155659	B. W	NG		09/24/	2021
					-		
NAME OF F	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP CODE		
					LD HWY # 60		
SELLERS	SBURG HEALTHC	ARE CENTER		SELLER	RSBURG, IN 47172		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROVIDEDIS DI ANI OE CODDECTIONI		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	i E	DATE
	-9/03/21 - day shift				Measures/systemic changes		
	-9/04/21 - night shi	ft			put into place to ensure the		
	-9/09/21 - night shi	ft			deficient practice does not		
	-9/16/21 - day shift				recur:		
	-9/17/21 - day shift				The Administrator/DON/Desig	nee	
	-9/21/21 - day shift				held an in-service for nursing	staff	
					to provide education and		
	During an interview	on 9/22/21 at 3:18 p.m., RN			expectations as it relates to th	е	
	3 indicated the TAF	R would be signed by the nurse			"Colostomy Appliance Bag		
	to show care had been provided.				Change" and documentation o	of	
					care provided per physician or	der	
	2. The clinical record for Resident K was				on the TAR.		
	reviewed on 9/22/21 at 12:19 p.m. Diagnoses				Corrective actions to be		
	included, but were not limited to, quadriplegia				monitored to ensure the		
	(paralysis) and sacr	al region pressure ulcer.			deficient practice will not rec	ur:	
					The DON/Unit Manager/Desig		
	-	d 1/18/21, indicated the			will audit 3 residents with a		
	resident had an alte	ration in bowel elimination		colostomy a week x 4 weeks, then			
	due to colostomy as	nd to provide assistance with			2 residents with colostomy a v	veek	
		pening in an organ of the			x 4 weeks, then 1 resident with		
		g an operation such as a			colostomy a week for 4 weeks		
	colostomy) care.				ensure completion of coloston	-	
					care per physician orders on t		
		nd September 2021 TAR			TAR. This will occur for no les		
		the ostomy site every shift			than 3 months and compliance	e is	
	with soap and water	r.			maintained.		
					The DON/Designee will prese		
		lacked documentation of			the results of these audits mor	-	
	colostomy care of the	he following dates and shifts:			to the QAPI committee for no		
		_			than 3 months. Any patterns t		
	-8/05/21 - night shi				are identified will have an Acti	on	
	-8/19/21 - day shift				Plan initiated. The QAPI		
	-8/23/21 - night shi				committee will determine when		
	-9/01/21 - day shift				100% compliance is achieved		
	-9/02/21 - day shift				if ongoing monitoring is require	ed.	
	-9/05/21 - day shift						
	-9/07/21 - day shift						
	-9/08/21 - day shift						
	-9/13/21 - day shift						
	-9/17/21 - day shift						

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  155659		 JILDING	00	(X3) DATE COMPL 09/24/	ETED	
	ROVIDER OR SUPPLIER		7823 OL	DDRESS, CITY, STATE, ZIP CODE LD HWY # 60 RSBURG, IN 47172		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
F 0725 SS=E Bldg. 00	Nursing provided a titled "Colostomy A 10/31/13. It included "PolicyIt is the popromote resident certo maintain the propand provide a comferenvironment"  This Federal tag relation of the environment and provide a comferenvironment"  This Federal tag relation of the environment and provide a comferenvironment"  This Federal tag relation of the environment and provide a comferenvironment"  This Federal tag relation of the environment and provide a comference and considering the number of the environment and the en	Staff ent Staff. ave sufficient nursing staff the competencies and skills rsing and related services safety and attain or est practicable physical, osocial well-being of each mined by resident individual plans of care and mber, acuity and acility's resident population in the facility assessment 0(e).  facility must provide ent numbers of each of the personnel on a 24-hour ursing care to all residents in resident care plans: aived under paragraph (e)				

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE	OATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED	
		155659	B. W	NG		09/24/	/2021	
				STREET	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	R			LD HWY # 60			
SELLER	SBURG HEALTHC	ARE CENTER			RSBURG, IN 47172			
	T				1.00010, 114 47 172			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	limited to nurse ai	des.						
	0400.05(-)(0).5							
		cept when waived under						
		his section, the facility						
	must designate a licensed nurse to serve as a charge nurse on each tour of duty.							
	_	on and interview, the facility	F 0	725	F 725 Sufficient Nursing Sta	ff	10/20/2021	
		equate staffing was provided to	FU	123	F 725 Sufficient Nursing Staff Corrective action for the		10/20/2021	
	meet the needs of the residents for 10 of 12 residents reviewed (Residents B, D, H, R, G, K, P, Q, S, T). This deficient practice had the				residents found to have bee	n		
					affected by the deficient			
					practice:			
	potential to affect 93 of 93 residents residing in				Resident B was identified as I	peina		
	the facility.				affected by the deficient pract	•		
					Resident D was identified as			
	Findings include:				being affected by the deficien	t		
					practice.			
	During an interviev	v on 9/21/21 at 12:50 p.m.,			Resident H was identified as I	being		
	Resident B indicate	ed he was supposed to get a			affected by the deficient pract	ice.		
	shower yesterday a	nd did not get one. When he			Resident R was identified as I	being		
	turns his call light of	on, it takes over an hour to get			affected by the deficient pract	ice.		
		nes the staff come in, turn off			Resident G was identified as			
		eave. He will turn on his call			being affected by the deficien	t		
		e to wait another hour for			practice.			
		ack. He was very frustrated			Resident K was identified as I	_		
	with the lack of hel	p.			affected by the deficient pract			
	D	0/21/21 + 11 50			Resident P was identified as I	•		
	_	v on 9/21/21 at 11:50 a.m., dicated there have been times			affected by the deficient pract Resident Q was identified as	ice.		
		le to complete her assigned			being affected by the deficien	ŧ		
		staff showing up for work.			practice.	ι		
	tasks due to fack of	start showing up for work.			Resident S was identified as I	neina		
	During an interview	v on 9/22/21 at 11:45 a.m.,			affected by the deficient pract	•		
	_	ed prior to this week, she had			Resident T was identified as b			
		shed in over 2 weeks. She told			affected by the deficient pract	•		
		o wash her hair because she			The deficient practice had the			
		o her appointment with dirty			potential to affect 93 of 93			
	hair. It took staff u	p to an hour to answer a call			residents residing in the facilit	:y		
	light. Some staff wi	ill come in, turn off the light,			Corrective action taken for			
		e back. She takes 40 mg			those residents having the			
	(milligrams) of Las	six every morning and was			potential to be affected by the	ne		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	LETED
		155659	B. W.		<del></del>	09/24/	
		100000				00/21/	72021
NAME OF I	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE		
					LD HWY # 60		
SELLER	SBURG HEALTHO	CARE CENTER		SELLER	RSBURG, IN 47172		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		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 APPROPRI	ATF	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	told by the staff sh	e could only get changed twice			same deficient practice:		
	on day shift and tv	vice on night shift. She told			All residents have the potenti	al to	
	staff at 11:30 a.m.	one day that she needed to be			be affected by the deficient		
	changed and was t	old she had to wait until after			practice.		
	lunch. It's usually	1:00 p.m. or 2:00 p.m. before			The facility staffing pattern ha	ıs	
	they get to her and	by then has laid in a wet brief,			been reviewed to ensure ade	quate	
	with a bed sore, fo	or 2 to 3 hours.			staffing is in place to meet the	9	
					needs of the residents.		
	During an intervie	w on 9/22/21 at 11:18 a.m.,			The facility has incentives in p	olace	
	Resident H indica	ted the facility was short			to promote hiring of nurses ar	nd	
	staffed. When she turns on her call light it can				CNAs. Further, the facility has		
take up to 2 hours for someone to answer her				contracted with agency group	s to		
	light. She knows when she has to go. She has had				assist in staffing the facility		
	_	in her bed as she does not			adequately.		
		se she knows when she has to			Measures/systemic changes	5	
	go. One day, her fa	amily had to call the front desk			put into place to ensure the		
		e someone to come and clean			deficient practice does not		
	_	t get a bath last week and she			recur:		
	_	the staff members there was			The Administrator/DON/Desig	gnee	
	1	or her to get a bath. When she			held an in-service for nursing		
	_	erself it makes her feel awful			to provide information as it re		
	and she feels as the	ough she was not getting the			to staffing of the facility,		
	care she deserves.				incentives offered, and agend	у	
					use.		
	During an intervie	w on 9/22/21 at 3:05 p.m.,			Corrective actions to be		
		ed there have been times she			monitored to ensure the		
	has turned her call	light on to be suctioned and			deficient practice will not re	cur:	
	has had to wait any	ywhere from 20 minutes to an			The Administrator/DON/Sche	dule	
	hour for her light t	to be answered. She knows			Coordinator/Designee will rev	view .	
	when she needs to	be suctioned and gets very			the daily schedules Monday		
	anxious when she	has to wait a long period for			through Friday to include		
	the staff to respond	d to her call light.			weekend schedules to ensure	Э	
	]				adequate staffing is in place a	as an	
	During an intervie	w on 9/23/21 at 1:03 p.m.,			ongoing practice. This will o	ccur	
		ted it takes the staff over an			for no less than 3 months and	t	
	hour or two to ans	wer her call light and she lays			compliance is maintained.		
	in a wet brief. The	y are very short staffed.			The Administrator/DON/Sche	dule	
					Coordinator/Designee will		
	During an intervie	w on 9/23/21 at 1:41 p.m.,			complete call light audits 3 da	ays a	
		ted her treatments are not			week x 4 weeks, then 2 days	-	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155659		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 09/24/2021	
	PROVIDER OR SUPPLIER SBURG HEALTHCARE CENTER	7823 O	ADDRESS, CITY, STATE, ZIP CODE OLD HWY # 60 RSBURG, IN 47172		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (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 APPROPRIA DEFICIENCY)	DATE	
IAG	being completed as ordered twice daily. She does get bathed but it can be a fight at times. It can take over an hour for her call light to be answered due to not enough staff.  During an interview on 9/23/21 at 3:45 p.m., Resident P indicated she has had bowel movements and had to wait over an hour to be changed.  During an interview on 9/24/21 at 9:00 a.m., Resident Q indicated she had urinated all over her bed waiting for staff to answer her call light." It's an awful feeling when you have an accident in the bed and makes you feel dirty, and then to have to lay in it for over an hour." She typically uses the bed pan. Staff will come in, especially at night, turn off the light, say they will be back and then do not come back.  During an interview and observation on 9/24/21 at 9:38 a.m. to 10:22 a.m., Resident S was observed with her call light on. The room was observed with a odor. The resident indicated she had a bowel movement and needed a bath. She had not had a bath for over 2 weeks as she had just returned from the hospital. The resident's call light was not answered until 10:22 a.m.  During an interview on 9/24/21 at 9:40 a.m., Resident T indicated her roommates (Resident S's) call light had already been on at least 15 minutes. Sometimes it takes staff over an hour to answer her roommates call light. They come in, turn off her light, say they will be back, and then don't come back for over an hour. There is just not enough staff.	IAG	week x 4 weeks, then 1 day a week x 4 weeks on rotating shrotating days and shifts to incl weekends to ensure call lights answered in a timely manner to ensure adequate staff are available. This will occur for less than 3 months and compliance is maintained. The Administrator/DON/SSD/Design will resident interviews with 3 residents a week x 4 weeks, then 1 resident a week x 4 weeks then 1 resident a week x 4 we to ensure staffing is sufficient answer call lights and needs a met. This will occur for no lest than 3 months and compliance maintained. The DON/Designee will prese the results of these audits monto the QAPI committee for no than 3 months. Any patterns are identified will have an Acti Plan initiated. The QAPI committee will determine whe 100% compliance is achieved if ongoing monitoring is required.	nifts ude sare and no gnee hen eks to are ss e is nt nthly less that on	
	On 9/24/21 at 9:53 a.m., CNA 9 was informed a resident at the end of the hallway was yelling for				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155659		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 09/24/2021	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7823 OLD HWY # 60 SELLERSBURG, IN 47172				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F 0759 SS=D Bldg. 00	yelling for help becanurse on the hall and soon as they could.  This Federal tag relations and they could.  This Federal tag relations and they could.  This Federal tag relations and they could also an interview facility must expected by the solutions and they could be percent or greated based on interview facility failed to ensume administered, as one of 3 residents review facility failed to ensume administered, as one of 3 residents review facility failed to ensume administered and they could be solved by the could be solved and they could be solved for the clinical record for 9/21/21 at 1:11 properties and they could be solved for the care plan, dated resident had an infermedications per phy.  The hospital discharing the could be solved for the care indicated the resident (antibiotic used to the infections) 100 mg (antibiotic used to the infections) 110 mg (antibiotic u	in Error Rts 5 Pront or More tion Errors. Insure that its- ication error rates are not er; and record review, the ure medications were dered by the physician, for 1 wed for medication errors.  For Resident C was reviewed a.m. Diagnoses included, but endocarditis, insomnia, and sorder.	F 07	759	F759 Free of Medication Error Rts 5 Pront or More 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 be affected by the deficient practice. An audit of medication administrations for the last 30 days has been completed. An identified concerns were	e I to	10/20/2021

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) D			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED
		155659	B. W	NG		09/24/2021
				CTREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER					
					LD HWY # 60	
SELLERS	SBURG HEALTHCA	ARE CENTER		SELLE	RSBURG, IN 47172	
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	indicated the antibio	otic was to be given at 5:00			immediately addressed.	
	a.m., 1:00 p.m., and				Measures/systemic changes	
	a.m., 1.00 p.m., and 7.00 p.m.				put into place to ensure the	
	The clinical record	indicated the resident did not			deficient practice does not	
		c on 7/14/21 at 5:00 a.m.			recur:	
	receive the antibioti	C On 7/14/21 at 3.00 a.m.			The DON/Unit Manager/Desig	nee
	The core plan detec	17/12/21, indicated the			held an in-service for all Licens	
	*	ychotic medications for			Nursing staff to provide educa	
	-	-				
		and to provide the medication			and expectations as it relates the "Modication Administration	
	as ordered by the pl	iysician.			the "Medication Administration	
	m 1 ' ' 1				Policy" and the timely	
	The admission orders indicated the resident was				administration of medications.	
	to receive Seroquel (medication used for anxiety				Corrective actions to be	
		mg in the morning and			monitored to ensure the	
		receive Seroquel 200 mg in			deficient practice will not rec	
	the evening.				The DON/Unit Manager/Desig	nee
					will complete a Medication	
		indicated the resident did not			Administration Observation for	<sup>.</sup> 2
	receive the 50 mg d				residents 3 days a week x 4	
	-	or the 200 mg dose in the			weeks, then 2 residents 2 days	
	evening on 7/10/21	or 7/11/21.			week x 4 weeks, then 1 reside	
					week for 4 weeks medications	
		er, dated 7/23/21, indicated			being administered timely. Th	is
	the resident was to i	receive an additional 100 mg			will occur for no less than 3	
	of Seroquel at bedti	me for 5 days.			months and compliance is	
					maintained.	
		indicated the medication was			The DON/Unit Manager/Desig	nee
	not administered on	7/23/21, 7/24/21, and			will present the results of these	e
	7/25/21.				audits monthly to the QAPI	
					committee for no less than 3	
	During an interview	on 9/23/21 at 12:30 p.m.,			months. Any patterns that are	
	The Director of Nu	rsing indicated the majority			identified will have an Action P	'lan
	of unsigned medica	tion administrations was			initiated. The QAPI committee	will
	staff not documenting	ng.			determine when 100% complia	ance
					is achieved or if ongoing	
	On 9/24/21 at 10:48	a.m., the Director of			monitoring is required.	
	Nursing provided a	current copy of the document			· ·	
	~ ·	Administration" dated				
		d, but was not limited to,				
		Medication Administration				
			- 1			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155659		(X2) MULTIPLE C A. BUILDING B. WING	OONSTRUCTION OO	(X3) DATE SURVEY COMPLETED 09/24/2021	
	ROVIDER OR SUPPLIER		7823 (	CADDRESS, CITY, STATE, ZIP CODE OLD HWY # 60 ERSBURG, IN 47172	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID  PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 0776 SS=D Bldg. 00	administrationIt is provide resident cen psychosocial, physic residentMedication given"  This Federal tag relation of the Indiana services of the services. Services of the services, the services of th	diagnostic Services ogy and other diagnostic facility must provide or and en eds of its residents.  In a provide its own diagnostic for a must meet the fins of participation for and in §482.26 of this for an er that is approved to for an er that is approved to for and record review, the for a vancomycin trough was for manner, for 1 of 3 residents	F 0776	F 776 Radiology/Other Diagnostic Services Corrective action for the residents found to have beer affected by the deficient practice: Resident C was identified as being affected by the deficient practice.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DA			JRVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. B	UILDING	00	COMPLET	ΓED
		155659	B. W	ING		09/24/20	021
				OTT DET	ADDRESS STEV STATE TIP SODE		
NAME OF F	ROVIDER OR SUPPLIEF	3		1	ADDRESS, CITY, STATE, ZIP CODE		
					LD HWY # 60		
SELLERS	SBURG HEALTHC	ARE CENTER		SELLER	RSBURG, IN 47172		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	were not limited to,	, endocarditis, chronic viral			Corrective action taken for		
	hepatitis, and sepsis	S.			those residents having the		
					potential to be affected by th	ie	
	The care plan, dated	d 7/12/21, indicated the			same deficient practice:		
	resident had an infe	ection and to obtain labs as			All residents requiring laborate	ory	
	ordered.				services have the potential to	be	
					affected by the deficient practi	ice.	
	The physician's ord	ler, dated 7/28/21, indicated to			A 30 day look back has been		
	obtain a vancomycin (antibiotic used to treat				completed to ensure laborator	-y	
	serious and life-thre	eatening infections) trough			services have been obtained.		
	(used to test the lov	vest concentration reached by			Any identified concerns were		
	a drug before the no	ext dose was administered) on			immediately addressed.		
	7/29/21.				Measures/systemic changes		
					put into place to ensure the		
	The progress note,	dated 7/30/21 at 3:41 a.m.,			deficient practice does not		
	indicated the vanco	mycin trough was missed on			recur:		
	7/29/21.				The Administrator/DON/Desig	nee	
					held an in-service for nursing	staff	
	The clinical record	lacked documentation of the			to provide education and		
	physician's notifica	tion or attempt to obtain the			expectations as it relates to th	е	
	missed trough.				"Laboratory and Radiological		
					Services and Results Reportir		
	During an interview	v on 9/23/21 at 10:01 a.m.,			as it relates to obtaining order	ed	
	LPN (Licensed Practice)	ctical Nurse) 5 indicated			laboratory services to include		
	when staff realized	the lab was missed, they			understanding the process an	d	
	should have called	the lab to have them draw it.			use of a vancomycin trough.		
					Corrective actions to be		
		8 a.m., the Director of			monitored to ensure the		
		current copy of the document			deficient practice will not rec		
	_	and Radiological Services and			The DON/Unit Manager/Desig		
		dated 3/22/19. It included,			will audit 5 residents a week x		
		to, "PolicyIt is the policy of			weeks, then 3 residents a wee		
		ide resident centered			4 weeks, then 1 resident a we		
		residentsis of primary			for 4 weeks to ensure labs we	re	
	importanceThe facility is responsible for the				obtained as ordered by the		
	quality and timeliness of servicesThere are clinicalrisks when laboratoryservices are not				physician. This will occur for i	no	
					less than 3 months and		
	performed in a time	ely manner"			compliance is maintained.		
					The DON/Unit Manager/Desig		
	This Federal tag rel	lates to Complaint			will present the results of thes	e	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155659	B. W	ING		09/24/2021	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			1	LD HWY # 60		
SELLERS	SBURG HEALTHCA	ARE CENTER			RSBURG, IN 47172		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	ER'S PLAN OF CORRECTION	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	IN00362077				audits monthly to the QAPI		
					committee for no less than 3		
	3.1-49(a)				months. Any patterns that are		
					identified will have an Action Plan		
				initiated. The QAPI committee			
					determine when 100% complia	ince	
					is achieved or if ongoing		
					monitoring is required.		
F 0880	483.80(a)(1)(2)(4)	(e)(f)					
SS=D	Infection Prevention						
Bldg. 00	§483.80 Infection						
· ·	The facility must e	stablish and maintain an					
	infection prevention	n and control program					
	designed to provid	le a safe, sanitary and					
	comfortable enviro	nment and to help prevent					
	the development a	and transmission of					
	communicable dis	eases and infections.					
	- , ,	on prevention and control					
	program.	atablish an infantian					
	_	stablish an infection ntrol program (IPCP) that					
	•	minimum, the following					
	elements:	minimum, the following					
	oromonio.						
	§483.80(a)(1) A sv	stem for preventing,					
		ng, investigating, and					
		ns and communicable					
	diseases for all res	sidents, staff, volunteers,					
	visitors, and other	individuals providing					
		ontractual arrangement					
	based upon the fa						
		ing to §483.70(e) and					
	following accepted	I national standards;					
	§483.80(a)(2) Writ	ten standards, policies,					
	- ' ' ' '	r the program, which must					
	include, but are no						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA				ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	00	COMPL	
		155659	B. W	ING		09/24/	/2021
MAMEOUT	DOMDED OF CLUBS IC.			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	X.		7823 OI	LD HWY # 60		
SELLER	SBURG HEALTHC	ARE CENTER		SELLEF	RSBURG, IN 47172		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		rveillance designed to					
		ommunicable diseases or					
		hey can spread to other					
	persons in the fac						
	_ ·	hom possible incidents of					
	communicable dis	sease or infections should					
	be reported;						
	(iii) Standard and transmission-based						
	precautions to be	followed to prevent spread					
	of infections;						
	(iv)When and how isolation should be used						
	for a resident; including but not limited to:						
	(A) The type and duration of the isolation,						
	1	he infectious agent or					
	organism involved						
		that the isolation should be e possible for the resident					
	under the circums						
		nces under which the					
	l ` '	bit employees with a					
		sease or infected skin					
		t contact with residents or					
		contact will transmit the					
	disease; and						
	l '	ene procedures to be					
	1 ' '	nvolved in direct resident					
	contact.						
	. , , , ,	ystem for recording					
		d under the facility's IPCP					
		actions taken by the					
	facility.						
	§483.80(e) Linens						
		andle, store, process, and					
	-	as to prevent the spread					
	of infection.						
	\$493 90/f) Appro-	roviow					
	§483.80(f) Annual	nduct an annual review of					
	i i i e i acility will co	nduct an annual leview U					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00 COM		COMPL	ETED	
		155659			09/24	/2021	
				CTREET	ADDRESS SITE STATE SID CODE		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
					DLD HWY # 60		
SELLER	SBURG HEALTHC	ARE CENTER		SELLE	RSBURG, IN 47172		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	BROWINEDIC DI AN OF CORRECTION	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION S		ULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		AIE	DATE
	its IPCP and upda	ate their program, as					
	necessary.						
	Based on observation	on, interview, and record	F 08	380			10/20/2021
		failed to ensure staff donned			F 880		
	appropriate persona	al protective equipment on the			Corrective action for the		
	yellow zone and fai	led to ensure face masks were		residents found to have been affected by the deficient		n	
	worn appropriately	for 2 of 5 staff observed for					
	infection control. (I				practice:		
				While on the yellow zone			
	Findings include:				(transmission based precaution	ons),	
					LPN 3 was observed		
	1. On 9/21/21 at 11:25 a.m., while on the yellow				administering medications with	thout	
	zone (transmission base precautions), LPN				a gown on.		
	(Licensed Practical Nurse) 3 was observed in a			LPN #6 was observed wearing her		g her	
	resident room administering medication without				mask under her nose when e	xiting	
	a gown on.				resident rooms on 200 hall		
					The deficient practice was		
	During an interview on 9/22/21 at 3:18 p.m., RN				identified to affect residents of	ared	
	2 indicated full PPE (personal protective				for by 2 of 5 staff observed fo	r	
	equipment), which	would include an N95, face			infection control.		
	shield, gloves, and	a gown) should be worn in			Corrective action taken for		
	resident rooms on the yellow zone.				those residents having the		
					potential to be affected by the	ne	
	2. During an observ	vation with LPN 5, on 9/23/21			same deficient practice:		
		was observed entering and			Rounds were immediately		
	exiting resident roo	ms on the 200 hall with her			completed by the Director of		
	face mask under he	r nose.			Nursing to ensure al staff wer	e	
					donning appropriate PPE		
		23/21 at 1:40 p.m., LPN 5	(personal protective equipment)		•		
		as educated to wear her mask			and face masks were being worn		
	correctly which was	s up over the nose.			appropriately by all staff.		
					Measures/systemic changes	3	
	On 9/24/21 at 10:48 a.m., the Director of			put into place to ensure the			
	Nursing provided a current copy of the document			deficient practice does not			
		evention Program" dated			recur:		
	3/9/2000. It included, but was not limited to,				The Administrator/Director of		
	"PolicyIt is the policy of this facility to provide				Nursing/Designee held an		
		are that meets theneeds of			in-service with the Director of		
		ents have a right to reside in a			Nursing to provide education	and	
	safe environment th	at promotes health and			expectations regarding the		

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	NT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA  OF CORRECTION IDENTIFICATION NUMBER:  155659	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 09/24/2021
	PROVIDER OR SUPPLIER SBURG HEALTHCARE CENTER	7823 O	ADDRESS, CITY, STATE, ZIP CODE ILD HWY # 60 RSBURG, IN 47172	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (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 APPROPRIA DEFICIENCY)	DATE
	reduces the risk of acquiring infectionsProcedureEducationEducation to staff on donning and doffing of personal protective equipment is a focus of the infection prevention program"  3.1-18(b)		"Infection Prevention" Program it relates to donning appropriat PPE and wearing the mask appropriately Corrective actions to be monitored to ensure the deficient practice will not red 1. The Administrator/Director Nursing/Designee will observe staff member daily (7 days a week) on rotating shifts to incl weekends to ensure PPE is be donned appropriately for 6 we and until compliance is maintained.  The Administrator/Director of Nursing/Designee will observe staff member daily (7 days a week) on rotating shifts to incl weekends to ensure the appropriate mask is worn over mouth and nose for 6 weeks a until compliance is maintained  1. The Administrator/Director Nursing/Designee will comple daily (7 days a week) visual rounds throughout the facility ensure staff are practicing appropriate Infection Control Practices and complying with solutions in B1 as above. This occur for 6 weeks and until compliance is maintained.  Administrator/Designee will present the results of these au monthly to the QAPI committe no less than 6 months. Any	te  cur:     of

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  155659	A. BUILDING 00  B. WING	COMPLETED - 09/24/2021
NAME OF PROVIDER OR SUPPLIER SELLERSBURG HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CO 7823 OLD HWY # 60 SELLERSBURG, IN 47172	DE
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRI PREFIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	DULD BE COMPLETION PROPRIATE DATE
	patterns that are identification have an Action Plan initication Plan initication Plan 100% compliance achieved or if ongoing mis required.	rector of rovided garding and doff stration, at to mask, es, gown, be CDC and rected and see of PPE vid 19  Use sipment Patients ected rected

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	OF CORRECTION	IDENTIFICATION NUMBER: 155659	A. BUILDING B. WING	00	COMPLETED 09/24/2021
NAME OF P	PROVIDER OR SUPPLIER	<u>.                                    </u>		ADDRESS, CITY, STATE, ZIP CODE	
SELLERS	SBURG HEALTHCA	ARE CENTER		DLD HWY # 60 RSBURG, IN 47172	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				Nursing/designee will provide education for all staff regarding the need to maintain face covering over the mouth and nose, as well as, the approprict covering to be used, at all time when in use.  - Facility Policy: Use of Facility, Covid 19 Isolation - Stop Signs - 1.Systemic:  1.A Root Cause Analysis (Facility Consultant Infection Preventionist (IP)/Medical Director/Facility IP/DON.  1.The Root Cause of the identified areas within the Faciliting is as follows: (DPOC) A Root Cause Analy (RCA) was conducted by the company Division (Consultant Infection Preventionist (IP), winput and review from the Medirector, Administrator, Region Director of Clinical Operations and Director of Nursing (DON determine the root cause result in the facilities Infection Contrictation.  Staffing numbers at the facility declined during the peak of the COVID 19 pandemic and conthrough the most recent COV 19 outbreak requiring the facility to obtain staff from outside	eng diate des PPE des

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEFICIES X1) PROVIDER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPP	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 09/24/2021	
	ROVIDER OR SUPPLIER SBURG HEALTHCARE CENTER	7823 O	ADDRESS, CITY, STATE, ZIP CODE DLD HWY # 60 RSBURG, IN 47172		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
			resources such as agency. The facility has an opportunity improve in their consistent infection control education for appropriate Infection control practices to include donning of PPE for Yellow zones, and appropriate wearing of mask of mouth and nose.  - 1.The facility with the Consultant IP have developed following solutions and system changes to address the root cause findings: These docum have been included with submission of the DPOC.  DPOC:  - The Administrator/Director Nursing/Designee will comple return demonstration of donning and doffing competency with sthat will need to enter an isolal room.  - The Administrator/Director Nursing/Designee will observe staff member daily (7 days a week) on rotating shifts to include weekends to ensure PPE is be donned appropriately for 6 we and until compliance is maintained.  - The Administrator/Director Nursing/Designee will observe staff member daily (7 days a week) on rotating shifts to include weekends to ensure the appropriate mask is worn over mouth and nose for 6 weeks a until compliance is maintained.	f over I the nic ents of tee ng staff tion of e 2 ude eing eks of e 2 ude the nig eks	

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	T OF DEFICIENCIES  OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155659	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 09/24/2021
	ROVIDER OR SUPPLIE		7823 C	ADDRESS, CITY, STATE, ZIP CODE DLD HWY # 60 RSBURG, IN 47172	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				1.The facility LTC Infection Control Self- Assessment has been reviewed and updated a appropriate to reflect an accur reflection of the facility with the Consultant IP/Medical Director/Facility IP/DON.  - 1.Training:  1.Training for staff has been implemented based on the Ro Cause Analysis and LTC Infecton Assessment findings.  1.The Consultant IP has provided training to the facility Administrator/DON/Unit Mana 2.Training for staff has be targeted to staff members who need to enter an isolation roor and all staff who are required wear a mask.  3.These training docume have been included with submission of the DPOC  1.Monitoring: Monitoring of approaches to ensure Infection Control Practices are maintained.  1.The Administrator/Director Nursing/Designee will observe staff member daily (7 days a week) on rotating shifts to incl weekends to ensure PPE is be donned appropriately for 6 we and until compliance is maintained.	ot stion  ger. een o will m to mts  of e 2  ude eing
				The Administrator/Director of	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00 CO		COMPLETED
		155659			09/24/2021
			STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER				DLD HWY # 60	
SELLER	SBURG HEALTHO	CARE CENTER		RSBURG, IN 47172	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	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 APPROPRI	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
				Nursing/Designee will observ	e 2
				staff member daily (7 days a	
				week) on rotating shifts to inc	lude
				weekends to ensure the	
				appropriate mask is worn ove	er the
				mouth and nose for 6 weeks	and
				until compliance is maintained	d.
				1.The Administrator/Directo	or of
				Nursing/Designee will comple	
				daily (7 days a week) visual	
				rounds throughout the facility	to
				ensure staff are practicing	
				appropriate Infection Control	
				Practices and complying with	
				solutions in B1 as above. Th	
				occur for 6 weeks and until	
				compliance is maintained.	
				E. Quality Assurance and	
				Performance improvement	
				(QAPI):	
				The Director of Nursing	
				present the results of these a	
				monthly to the QAPI committe	ee for
				review and to update or ma	
				changes to the DPOC as nee	
				to maintain substantial compl	iance
				for no less than 6 months. Ar	-
				patterns that are identified wil	
				have an Action Plan initiated.	
				QAPI committee will determine	ne
				when 100% compliance is	
				achieved or if ongoing monitor	oring
				is required.	

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