STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155659	B. WING		11/10/2021
			CTREET	ADDRESS SERVI STATE TIP CODE	
NAME OF P	ROVIDER OR SUPPLIEF	3		ADDRESS, CITY, STATE, ZIP CODE	
				DLD HWY # 60	
SELLERSBURG HEALTHCARE CENTER			SELLE	RSBURG, IN 47172	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		(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
F 0000					
Bldg. 00					
	This visit was for a	Post Survey Revisit (PSR) to	F 0000	Preparation or execution of t	his
		Complaints IN00361266,	1 0000	plan of correction does not	
	_	362236, IN00362911,		constitute admission or	
		Focused COVID-19		agreement of provider of the	
		urvey completed on		truth of the facts alleged or	
	9/24/2021.	arrey completed on		conclusions set forth on the	
	712T12U21.			State of Deficiencies. The Pla	an
	This visit was in co	niunction with the		of Correction is prepared and	
		mplaints IN00365045,		executed solely because it is	l l
	IN00365928, and II	•		required by the position of	'
	11N00303926, and 11	100300314.		Federal and State Law.	
	Commissint INIO0261	1266 Not competed		The Plan of Correction is	
	Complaint invoso	1266 - Not corrected.			4
	C1-:4 IN10026	2077 C		submitted in order to respon	u
	Complaint IN00362	20// - Corrected.		to the allegation of	tha
	C1-:4 IN10026	2226 - Gamarata 1		noncompliance cited during	
	Complaint IN00362	2230 - Corrected.		complaint survey and revisit conducted on November	
	Complaint IN00362	2011 Commented		10,2021. Please accept this	
	Complaint 1100302	2911 - Collected.		plan of correction as the	
	Complaint IN00363	2001 Corrected		provider's credible allegation	n of
	Complaint 1140030.	5071 - Corrected		compliance.	
	Survey dates: Nov	ember 9 and 10, 2021		The facility would like to	
	Sarvey dates. 1909	omoor 7 and 10, 2021		respectfully request a desk	
	Facility number: 0	10613		review.	
	Provider number: 1			Thank you,	
	AIM number: 2002			Jill Dirbas, LNHA	
	Anvi number. 2002	22 I VTV		Jiii Dii Das, LINA	
	Census Bed Type:				
	SNF/NF: 99				
	Total: 99				
	10tai. 77				
	Census Payor Type				
	Medicare: 20				
	Medicaid: 65				
	Other: 14				
	Total: 99				
	10tai: 99				

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

TITLE

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.

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

(X6) DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	f 1			TE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
		155659	B. W	NG	<u> </u>	11/10/	2021
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					LD HWY # 60		
SELLERS	SBURG HEALTHCA	ARE CENTER		SELLER	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	DEFICIENCY)	1E	DATE
	These deficiencies r	reflect State Findings cited in					
	accordance with 410	9					
	Ouality review com	pleted on November 19,					
	2021.	1					
	· ·						
F 0686	483.25(b)(1)(i)(ii)						'
SS=D	. , , , , , , ,	Prevent/Heal Pressure					
Bldg. 00	Ulcer						
· ·	§483.25(b) Skin In	ntegrity					
	§483.25(b)(1) Pres						
	- ' ' ' '	prehensive assessment of					
		ility must ensure that-					
	· ·	ives care, consistent with					
		lards of practice, to prevent					
		nd does not develop					
		nless the individual's clinical					
	•	trates that they were					
	unavoidable; and	liates that they were					
		pressure ulcers receives					
		ent and services, consistent					
		standards of practice, to					
		prevent infection and					
	prevent new ulcers						11/20/2021
		and record review, the	F 00	086	5 000 Tue star and/Occas 4		11/29/2021
		ure wound treatments were			F 686 Treatment/Svcs to		
	-	4 residents (Residents C, D,			Prevent/Heal Pressure Ulcer		
		d treatment orders were			Corrective action for the		
	•	ered by the physician			residents found to have been	1	
		of 3 residents reviewed for			affected by the deficient		
	pressure ulcers.				practice:		
					Resident C was identified as		
	Findings include:				being affected by the deficient		
		10.5.11.0			practice.		
		rd for Resident C was			Resident D was identified as		
		1 at 3:22 p.m. Diagnosis			being affected by the deficient		
	·	ot limited to, stage 4 (ulcer			practice.		
		the subcutaneous fat into the			Resident F was identified as b	•	
	_	iscle, tendons, and ligaments)			affected by the deficient practi	ce.	
	sacral region pressu	re ulcer. The quarterly MDS			Corrective action taken for		
			1		i e e e e e e e e e e e e e e e e e e e	l	1

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Event ID:

AJ7O12

Facility ID: 010613

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155659	B. W	ING		11/10/	2021
							-
NAME OF F	PROVIDER OR SUPPLIEF	t			ADDRESS, CITY, STATE, ZIP CODE		
					LD HWY # 60		
SELLERS	SBURG HEALTHC	ARE CENTER		SELLE	RSBURG, IN 47172		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	BROWINEDIC DI ANI OF CORDECTION		(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	DEFICIENCY)	.16	DATE
	(Minimum Data Se	t) assessment, dated			those residents having the		
	10/18/21, indicated	the resident's cognition was			potential to be affected by th	e	
	intact.				same deficient practice:		
					All residents at risk for or who		
	The care plan, dated	d 4/27/21, indicated the			currently have wound treatme	nts	
	resident had impair	ed skin integrity and to			have the potential to be affect	ed	
	administer treatmer	nts as ordered by the medical			by the deficient practice.		
	provider.				An audit of last 30 days for		
					residents having wounds has	been	
	The wound evaluat	ion report, dated 10/5/21,			completed for review of treatm	nents	
	indicated the reside	nt had a stage 4 sacral wound			implemented and completed a	ıs	
	which measured 2.3	34 cm (centimeters) in length,			ordered by the physician.		
	3.99 cm in width w	ith a depth of 2.6 cm. The area			Measures/systemic changes		
	was to be cleansed	with wound cleanser, collagen			put into place to ensure the		
	dressing applied, ar	nd covered with bordered			deficient practice does not		
	foam daily.				recur:		
					The Administrator/DON/Desig	nee	
	Review of the Octo	ber 2021 treatment			held an in-service for nursing	staff	
	administration reco	rd indicated the treatment			to provide education and		
	was not completed	on 10/20/21, 10/23/21, and			expectations as it relates to th	е	
	10/24/21.				"Monitoring a Wound" and		
					documentation of treatment		
	The wound evaluat	ion report, dated 11/2/21,			completion on the TAR.		
	indicated the reside	nt had a stage 4 sacral wound			Corrective actions to be		
	which measured 1.7	74 cm in length, 3.39 cm in			monitored to ensure the		
	width with a depth	of 1.5 cm.			deficient practice will not red		
					The DON/Wound Nurse/Desig	gnee	
	_	v on 11/10/21 at 5:51 p.m.,			will audit 2 residents with wou		
	LPN (Licensed Practice)	ctical Nurse) 3 indicated			3 days a week x 4 weeks, the	n 2	
	when a treatment w	ras completed, the nurse			residents 2 days a week x 4		
	signed off the treatr	ment on the administration			weeks, then 1 resident a week		
	record.				4 weeks to ensure the treatme		
					was implemented and comple		
		rd for Resident D was			per physician orders on the T		
		1 at 3:47 p.m. Diagnosis			This will occur for no less thar	13	
		ot limited, a stage 4 pressure			months and compliance is		
	ulcer to the left isch	nium.			maintained.		
					The DON/Wound Nurse/Desig		
	_	d 2/23/21, indicated the			will present the results of thes	е	
	resident had a press	sure ulcer and to provide			audits monthly to the QAPI		

PRINTED: 12/01/2021 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155659	ľ	JILDING	instruction 00	(X3) DATE : COMPL 11/10/	ETED
	PROVIDER OR SUPPLIER		<u> </u>	7823 OI	ADDRESS, 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
	wound care per treat. The wound evaluation indicated the resider ulcer to the left ischein length, 0.5 cm in the October 2021 to record indicated the with wound cleanse applied, and covereshift. The treatment 10/22/21 on day shift. The wound evaluation indicated the resider ulcer to the left ischein length, 0.5 cm in the 10/26/21 and 1 report indicated the wound cleanser, pat and cover with bords. Review of the October 2021 treatment admits between 10/26/21 at was completed daily as ordered by the pheron 3. The clinical record reviewed on 11/9/20 included, but was not ulcer to the coccyx. The care plan, dated resident had a stage coccyx and to composite to the composite to the coccyx.	on report, dated 10/12/21, at had a stage 4 pressure ium which measured 0.8 cm width with a depth of 0.4 cm. reatment administration wound was to be cleansed r, patted dry, calcium alginate d with a foam dressing every was not completed on ft. on report, dated 10/26/21, at had a stage 4 pressure ium which measured 0.8 cm width with a depth of 0.4 cm. 1/2/21 wound evaluation area was to be cleansed with ted dry, medihoney applied, ered foam every other day. oer 2021 and November inistration record indicated, and 11/9/21, the treatment or rather than every other day bysician. d for Resident F was at 4:23 p.m. Diagnosis of limited to, stage 4 pressure			committee for no less than 3 months. Any patterns that are identified will have an Action Finitiated. The QAPI committee determine when 100% complis is achieved or if ongoing monitoring is required.	Plan will	

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Event ID:

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	OF CORRECTION	IDENTIFICATION NUMBER: 155659	A. BU	A. BUILDING 00 B. WING		COMPLETED 11/10/2021	
NAME OF P	PROVIDER OR SUPPLIER				NDDRESS, CITY, STATE, ZIP CODE LD HWY # 60		
SELLERS	SBURG HEALTHCA	RE CENTER			RSBURG, IN 47172		
(X4) ID PREFIX TAG	(EACH DEFICIENC	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 APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	measured 7.72 cm ir with a depth of 0.5 c cleansed with wound (wound debriding ag twice daily. Review of the Octob	wound was unstagebale and a length, 5.46 cm in width cm. The area was to be d cleanser, patted dry, Dakin's gent) moist to dry applied over 2021 treatment d indicated the treatment					
	was not completed of	on 10/20/21 and 10/24/21. on report, dated 10/26/21, measured 6.24 cm in length,					
	This deficiency was	th a depth of 0.5 cm. cited on 9/24/2021. The element a systemic plan of t recurrence.					
	but was not limited to resident/patient is ev	nd" dated 7/1/16, included, to, "PolicyEach valuated upon reImplement wound					
	3.1-40(a)(2)						
F 0690 SS=D Bldg. 00	§483.25(e) Incontil §483.25(e)(1) The resident who is col bowel on admissio assistance to main or her clinical cond	ontinence, Catheter, UTI nence. facility must ensure that ntinent of bladder and in receives services and itain continence unless his dition is or becomes such not possible to maintain.					
		a resident with urinary ed on the resident's					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155659	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 11/10/2021
	PROVIDER OR SUPPLIER		7823 C	ADDRESS, CITY, STATE, ZIP CODE DLD HWY # 60 ERSBURG, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	ensure that- (i) A resident who an indwelling cath unless the resident demonstrates that necessary; (ii) A resident who indwelling cathete one is assessed for as soon as possibility clinical condition of catheterization is receives appropriate to prevent urinary restore continences §483.25(e)(3) For incontinence, base comprehensive as ensure that a reside bowel receives appropriate to prevent urinary restore continence for incontinence, base comprehensive as ensure that a reside bowel receives appropriately failed to ensure that a reside bowel receives appropriately failed to ensure that a reside bowel receives appropriately failed to ensure that a resident of the sacral recording includes. 1. The clinical recording included, but was not ulcer of the sacral recording included, but was not ulcer of the sacral recording included, but was not ulcer of the sacral recording included, but was not ulcer of the sacral recording included, but was not ulcer of the sacral recording included, but was not ulcer of the sacral recording included, but was not ulcer of the sacral recording included, but was not ulcer of the sacral recording included, but was not ulcer of the sacral recording included.	necessary; and o is incontinent of bladder ate treatment and services tract infections and to e to the extent possible. a resident with fecal ed on the resident's esessment, the facility must dent who is incontinent of propriate treatment and e as much normal bowel le. and record review, the ure Foley catheter care was ed by the physician, for 2 of d for Indwelling catheters. ord for Resident B was 1 at 3:01 p.m. Diagnosis ot limited to, stage 4 pressure	F 0690	F 690 Bowel/Bladder Incontinence, Catheter, UTI Corrective action for the residents found to have beer affected by the deficient practice: Resident B was identified as be affected by the deficient practi Resident C was identified as being affected by the deficient practice. Corrective action taken for those residents having the potential to be affected by th	eing ce.

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Facility ID: 010613

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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	ETED
		155659	B. W	ING		11/10/	2021
		10000		_		1 17 107	
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
					LD HWY # 60		
SELLERS	SBURG HEALTHC	ARE CENTER		SELLER	RSBURG, IN 47172		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		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 APPROPRI	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	to impaired skin in	tegrity and to provide catheter			same deficient practice:		
	care every shift.				All residents with foley cathet		
					have the potential to be affect	ted	
		ler, dated 9/8/21, indicated to			by the deficient practice.		
	clean the Foley cat	heter with soap and water			An audit of the last 30 days fo		
	every shift.				residents having foley cathete		
					has been completed to ensur	е	
		ober 2021 treatment			foley catheter care has been		
	administration reco	ord indicated the catheter care			completed as ordered by the		
	was not completed	on 10/21//21 (day shift).			physician.		
					Any identified concerns were		
	-	w on 11/10/21 at 5:51 p.m.,			immediately addressed.		
	· ·	ectical Nurse) 3 indicated the			Measures/systemic changes		
	treatment administr	ration record would be signed			put into place to ensure the		
	by the nurse to sho	w care had been provided.			deficient practice does not		
					recur:		
		ord for Resident C was			The Administrator/DON/Desi		
		21 at 3:22 p.m. Diagnoses			held an in-service for nursing	staff	
		not limited to, quadriplegia,			to provide education and		
	neurogenic bladder	, and sacral region pressure			expectations as it relates to the	ne	
	ulcer.				"Catheter Care" and		
					documentation of care provid		
	-	d 1/18/21, indicated the			per physician order on the TA	AR.	
		welling Catheter and to			Corrective actions to be		
	provide catheter ca	re every shift.			monitored to ensure the		
					deficient practice will not re		
		treatment administration			The DON/Unit Manager/Design	gnee	
		cleanse the Indwelling			will audit 3 residents with		
	urinary catheter ev	ery shift with soap and water.			catheters a week x 4 weeks,		
					2 residents with catheters a w		
		lacked documentation of			x 4 weeks, then 1 resident wi		
		/20/21 (day shift) and			catheter a week for 4 weeks t		
	10/24/21 (day shift).			ensure completion of cathete		
	TELL 1 CC :	. 1 0/04/0001 75			care per physician orders on		
	•	s cited on 9/24/2021. The			TAR. This will occur for no le		
		plement a systemic plan of			than 3 months and compliand	e is	
	correction to preve	nt recurrence.			maintained.		
	and the				The DON/Designee will prese		
		titled "Catheter Care" dated			the results of these audits mo	-	
	10/13/2013, includ	ed, but was not limited to,			to the QAPI committee for no	less	

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING O B. WING			(X3) DATE COMPL 11/10/	ETED		
NAME OF PROVIDER OF				7823 O	ADDRESS, CITY, STATE, ZIP CODE LD HWY # 60 RSBURG, IN 47172		
PREFIX (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 APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
"PolicyI resident coresidents. twice dail catheters, place" 3.1-41(a)(1) F 0691	y, Urosto y on resid for as lon 2) y, Urosto y Colosto y care. ty must e blostomy receive s nal stand ensive pe esident's interview led to ensias ordered s B and C nclude: nical record	dicy of this facility to provide eets theneedsof the care is performed at least ents that have indwelling g as the catheter is in omy, or lleostomy Care omy, urostomy, or ensure that residents who a urostomy, or ileostomy such care consistent with lards of practice, the erson-centered care plan, goals and preferences. and record review, the enter colostomy care was d by the physician, for 2 of 2 for special needs devices. Out of or Resident B was call at 3:01 p.m. Diagnosis of limited to, colostomy ber 2021 TAR (treatment and indicated the resident's to be cleaned with soap and lacked documentation of	F 00		than 3 months. Any patterns to are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved if ongoing monitoring is required to a corrective action for the residents found to have been affected by the deficient practice: Resident B was identified as being affected by the deficient practice. Resident C was identified as being affected by the deficient practice. Corrective action taken for those residents having the potential to be affected by the same deficient practice: All residents with colostomy have the potential to be affected by deficient practice. An audit of the last 30 days for	eing ce.	11/29/2021
colostomy	care on 1	0/21/21 on day shift.			residents having a colostomy l been completed to ensure	nas	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLE	ETED
		155659	B. W	ING		11/10/2	2021
				CERCE	A DODDEGG CHTM CT ATE THE CODE		
NAME OF P	ROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP CODE		
					LD HWY # 60		
SELLERS	SBURG HEALTHC	ARE CENTER		SELLEI	RSBURG, IN 47172		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	v on 11/10/21 at 5:51 p.m.,			colostomy care has been		
	LPN (Licensed Pra	ctical Nurse) 3 indicated the			completed as ordered by the		
	TAR would be sign	ned by the nurse to show care			physician.		
	had been provided.				Any identified concerns were		
					immediately addressed.		
	2. The clinical reco	ord for Resident C was			Measures/systemic changes	;	
	reviewed on 11/9//2	21 at 3:22 p.m. Diagnoses			put into place to ensure the		
	included, but were	not limited to, quadriplegia			deficient practice does not		
	and sacral region p	ressure ulcer.			recur:		
					The Administrator/DON/Desig	nee	
	The care plan, date	d 1/18/21, indicated the			held an in-service for nursing	staff	
	resident had an alte	eration in bowel elimination			to provide education and		
	due to colostomy as	nd to provide assistance with			expectations as it relates to th	ie	
	ostomy care.	•			"Colostomy Appliance Bag		
	,				Change" and documentation of	of	
	The October 2021	TAR indicated to cleanse the			care provided per physician o		
		shift with soap and water.			on the TAR.		
					Corrective actions to be		
	The clinical record	lacked documentation of			monitored to ensure the		
		10/20/21 (day shift) and			deficient practice will not red	cur:	
	10/24/21 (day shift	· · ·			The DON/Unit Manager/Desig		
		,			will audit 3 residents with a		
	This deficiency was	s cited on 9/24/2021. The			colostomy a week x 4 weeks,	then	
		plement a systemic plan of			2 residents with colostomy a		
	correction to preven				x 4 weeks, then 1 resident wit		
	1				colostomy a week for 4 weeks		
	A current copy of t	he document titled			ensure completion of colostor		
		ance Bag Change" dated			care per physician orders on t	-	
		, but was not limited to,			TAR. This will occur for no le		
		olicy of this facility to			than 3 months and complianc	e is	
		entered care by providing care			maintained.		
	-	per function of the colostomy			The DON/Designee will prese	nt l	
		fortable and hygienic			the results of these audits mo		
	environment"	<i>, 6</i> 			to the QAPI committee for no	-	
					than 3 months. Any patterns		
	3.1-47(a)(3)				are identified will have an Acti		
	2.1 1/(<i>u)</i> (3)				Plan initiated. The QAPI		
					committee will determine whe	n	
					100% compliance is achieved		
					if ongoing monitoring is requir		
			1		I in origining mornitoring is requir	cu.	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155659	A. BUILDING 00 B. WING			(X3) DATE SURVEY COMPLETED 11/10/2021	
	PROVIDER OR SUPPLIER SBURG HEALTHCA			7823 O	ADDRESS, CITY, STATE, ZIP CODE LD HWY # 60 RSBURG, IN 47172		
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: AJ7O12 Facility ID: 010613 If continuation sheet Page 10 of 10