STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155659	A. BUILDING 00 B. WING	11/10/2021

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

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F 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaints IN00361266, IN00362077, IN00362236, IN00362911, IN00363091, and a Focused COVID-19 Infection Control Survey completed on 9/24/2021. This visit was in conjunction with the Investigation of Complaints IN00365045, IN00365928, and IN00366314. Complaint IN00361266 - Not corrected. Complaint IN00362077 - Corrected. Complaint IN00362236 - Corrected. Complaint IN00362911 - Corrected. Complaint IN00363091 - Corrected Survey dates: November 9 and 10, 2021 Facility number: 010613 Provider number: 155659 AIM number: 200221040 Census Bed Type: SNF/NF: 99 Total: 99 Census Payor Type: Medicare: 20 Medicaid: 65 Other: 14 Total: 99	F 0000	**Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law.** **The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the complaint survey and revisit conducted on November 10,2021. Please accept this plan of correction as the provider's credible allegation of compliance.** **The facility would like to respectfully request a desk review.** **Thank you,** **Jill Dirbas, LNHA**	

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

Any deficiencystatement 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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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 19, 2021.			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on interview and record review, the facility failed to ensure wound treatments were completed for 3 of 4 residents (Residents C, D, and F) reviewed and treatment orders were implemented as ordered by the physician (Resident D) for 1 of 3 residents reviewed for pressure ulcers. Findings include: 1. The clinical record for Resident C was reviewed on 11/9/21 at 3:22 p.m. Diagnosis included, but was not limited to, stage 4 (ulcer that extends below the subcutaneous fat into the deep tissues like muscle, tendons, and ligaments) sacral region pressure ulcer. The quarterly MDS	F 0686	**F 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer** **Corrective action for the residents found to have been affected by the deficient practice:** Resident C was identified as being affected by the deficient practice. Resident D was identified as being affected by the deficient practice. Resident F was identified as being affected by the deficient practice. **Corrective action taken for**	11/29/2021

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	(Minimum Data Set) assessment, dated 10/18/21, indicated the resident's cognition was intact. The care plan, dated 4/27/21, indicated the resident had impaired skin integrity and to administer treatments as ordered by the medical provider. The wound evaluation report, dated 10/5/21, indicated the resident had a stage 4 sacral wound which measured 2.34 cm (centimeters) in length, 3.99 cm in width with a depth of 2.6 cm. The area was to be cleansed with wound cleanser, collagen dressing applied, and covered with bordered foam daily. Review of the October 2021 treatment administration record indicated the treatment was not completed on 10/20/21, 10/23/21, and 10/24/21. The wound evaluation report, dated 11/2/21, indicated the resident had a stage 4 sacral wound which measured 1.74 cm in length, 3.39 cm in width with a depth of 1.5 cm. During an interview on 11/10/21 at 5:51 p.m., LPN (Licensed Practical Nurse) 3 indicated when a treatment was completed, the nurse signed off the treatment on the administration record. 2. The clinical record for Resident D was reviewed on 11/9/21 at 3:47 p.m. Diagnosis included, but was not limited, a stage 4 pressure ulcer to the left ischium. The care plan, dated 2/23/21, indicated the resident had a pressure ulcer and to provide		**those residents having the potential to be affected by the same deficient practice:** All residents at risk for or who currently have wound treatments have the potential to be affected by the deficient practice. An audit of last 30 days for residents having wounds has been completed for review of treatments implemented and completed as ordered by the physician. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/DON/Designee held an in-service for nursing staff to provide education and expectations as it relates to the "Monitoring a Wound" and documentation of treatment completion on the TAR. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON/Wound Nurse/Designee will audit 2 residents with wounds 3 days a week x 4 weeks, then 2 residents 2 days a week x 4 weeks, then 1 resident a week for 4 weeks to ensure the treatment was implemented and completed per physician orders on the TAR. This will occur for no less than 3 months and compliance is maintained. The DON/Wound Nurse/Designee will present the results of these audits monthly to the QAPI	

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	wound care per treatment order. The wound evaluation report, dated 10/12/21, indicated the resident had a stage 4 pressure ulcer to the left ischium which measured 0.8 cm in length, 0.5 cm in width with a depth of 0.4 cm. The October 2021 treatment administration record indicated the wound was to be cleansed with wound cleanser, patted dry, calcium alginate applied, and covered with a foam dressing every shift. The treatment was not completed on 10/22/21 on day shift. The wound evaluation report, dated 10/26/21, indicated the resident had a stage 4 pressure ulcer to the left ischium which measured 0.8 cm in length, 0.5 cm in width with a depth of 0.4 cm. The 10/26/21 and 11/2/21 wound evaluation report indicated the area was to be cleansed with wound cleanser, patted dry, medihoney applied, and cover with bordered foam every other day. Review of the October 2021 and November 2021 treatment administration record indicated, between 10/26/21 and 11/9/21, the treatment was completed daily rather than every other day as ordered by the physician. 3. The clinical record for Resident F was reviewed on 11/9/21 at 4:23 p.m. Diagnosis included, but was not limited to, stage 4 pressure ulcer to the coccyx. The care plan, dated 5/11/21, indicated the resident had a stage 4 pressure ulcer to the coccyx and to complete treatments as ordered. The wound evaluation report, dated 10/12/21,		committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	indicated the coccyx wound was unstagebale and measured 7.72 cm in length, 5.46 cm in width with a depth of 0.5 cm. The area was to be cleansed with wound cleanser, patted dry, Dakin's (wound debriding agent) moist to dry applied twice daily. Review of the October 2021 treatment administration record indicated the treatment was not completed on 10/20/21 and 10/24/21. The wound evaluation report, dated 10/26/21, indicated the wound measured 6.24 cm in length, 6.49 cm in width with a depth of 0.5 cm. This deficiency was cited on 9/24/2021. The facility failed to implement a systemic plan of correction to prevent recurrence. A current copy of the document titled "Monitoring A Wound" dated 7/1/16, included, but was not limited to, "Policy...Each resident/patient is evaluated upon admission...Procedure...Implement wound treatments as ordered. 3.1-40(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's			

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	comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview and record review, the facility failed to ensure Foley catheter care was completed, as ordered by the physician, for 2 of 3 residents reviewed for Indwelling catheters. (Residents B and C) Findings include: 1. The clinical record for Resident B was reviewed on 11/9//21 at 3:01 p.m. Diagnosis included, but was not limited to, stage 4 pressure ulcer of the sacral region. The care plan, dated 9/8/21, indicated the resident had a Foley (Indwelling) catheter related	F 0690	**F 690 Bowel/Bladder Incontinence, Catheter, UTI** **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**	11/29/2021

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	to impaired skin integrity and to provide catheter care every shift. The physician's order, dated 9/8/21, indicated to clean the Foley catheter with soap and water every shift. Review of the October 2021 treatment administration record indicated the catheter care was not completed on 10/21//21 (day shift). During an interview on 11/10/21 at 5:51 p.m., LPN (Licensed Practical Nurse) 3 indicated the treatment administration record would be signed by the nurse to show care had been provided. 2. The clinical record for Resident C was reviewed on 11/9/21 at 3:22 p.m. Diagnoses included, but were not limited to, quadriplegia, neurogenic bladder, and sacral region pressure ulcer. The care plan, dated 1/18/21, indicated the resident had an Indwelling Catheter and to provide catheter care every shift. The October 2021 treatment administration record indicated to cleanse the Indwelling urinary catheter every shift with soap and water. The clinical record lacked documentation of catheter care on 10/20/21 (day shift) and 10/24/21 (day shift). This deficiency was cited on 9/24/2021. The facility failed to implement a systemic plan of correction to prevent recurrence. The current policy titled "Catheter Care" dated 10/13/2013, included, but was not limited to,		**same deficient practice:** All residents with foley catheters have the potential to be affected by the deficient practice. An audit of the last 30 days for residents having foley catheters has been completed to ensure foley catheter care has been completed as ordered by the physician. Any identified concerns were immediately addressed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/DON/Designee held an in-service for nursing staff to provide education and expectations as it relates to the "Catheter Care" and documentation of care provided per physician order on the TAR. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON/Unit Manager/Designee will audit 3 residents with catheters a week x 4 weeks, then 2 residents with catheters a week x 4 weeks, then 1 resident with a catheter a week for 4 weeks to ensure completion of catheter care per physician orders on the TAR. This will occur for no less than 3 months and compliance is maintained. The DON/Designee will present the results of these audits monthly to the QAPI committee for no less	

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	"Policy...It is the policy of this facility to provide resident care that meets the...needs...of the residents. Catheter care is performed at least twice daily on residents that have indwelling catheters, for as long as the catheter is in place...." 3.1-41(a)(2)		than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
F 0691 SS=D Bldg. 00	483.25(f) Colostomy, Urostomy, or Ileostomy Care §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on interview and record review, the facility failed to ensure colostomy care was provided, as ordered by the physician, for 2 of 2 residents reviewed for special needs devices. (Residents B and C) Findings include: 1. The clinical record for Resident B was reviewed on 11/9//21 at 3:01 p.m. Diagnosis included, but was not limited to, colostomy status. Review of the October 2021 TAR (treatment administration record) indicated the resident's colostomy site was to be cleaned with soap and water every shift. The clinical record lacked documentation of colostomy care on 10/21/21 on day shift.	F 0691	**F 691 Colostomy, Urostomy, Ileostomy Care** **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 the deficient practice. An audit of the last 30 days for residents having a colostomy has been completed to ensure	11/29/2021

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	During an interview on 11/10/21 at 5:51 p.m., LPN (Licensed Practical Nurse) 3 indicated the TAR would be signed by the nurse to show care had been provided. 2. The clinical record for Resident C was reviewed on 11/9//21 at 3:22 p.m. Diagnoses included, but were not limited to, quadriplegia and sacral region pressure ulcer. The care plan, dated 1/18/21, indicated the resident had an alteration in bowel elimination due to colostomy and to provide assistance with ostomy care. The October 2021 TAR indicated to cleanse the ostomy site every shift with soap and water. The clinical record lacked documentation of colostomy care on 10/20/21 (day shift) and 10/24/21 (day shift). This deficiency was cited on 9/24/2021. The facility failed to implement a systemic plan of correction to prevent recurrence. A current copy of the document titled "Colostomy Appliance Bag Change" dated 10/31/13, included, but was not limited to, "Policy...It is the policy of this facility to promote resident centered care by providing care to maintain the proper function of the colostomy and provide a comfortable and hygienic environment...." 3.1-47(a)(3)		colostomy care has been completed as ordered by the physician. Any identified concerns were immediately addressed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/DON/Designee held an in-service for nursing staff to provide education and expectations as it relates to the "Colostomy Appliance Bag Change" and documentation of care provided per physician order on the TAR. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON/Unit Manager/Designee will audit 3 residents with a colostomy a week x 4 weeks, then 2 residents with colostomy a week x 4 weeks, then 1 resident with a colostomy a week for 4 weeks to ensure completion of colostomy care per physician orders on the TAR. This will occur for no less than 3 months and compliance is maintained. The DON/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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