STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155659		A. BU	X2) MULTIPLE CONSTRUCTION X3) DATE A. BUILDING 00 COMP B. WING 01/20			ETED	
	PROVIDER OR SUPPLIE			7823 O	ADDRESS, CITY, STATE, ZIP COD LD HWY # 60 RSBURG, IN 47172		
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DUGG DEFITE YOUR DEFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION
TAG F 0000	REGULATORY O	R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY /		DATE
F 0000 Bldg. 00	Control Survey and Complaints IN003 Complaint IN0037 Federal/State deficiallegations are cite Complaint IN0037 deficiencies related Survey dates: Janu Facility number: 0 Provider number: AIM number: 2000 Census Bed Type: SNF/NF: 93 Total: 93 Census Payor Type Medicare: 11 Medicaid: 61 Other: 21 Total: 93 These deficiencies accordance with 4	155659 221040 e: reflect State findings cited in	F 00	000	Preparation or execution of this plan of correction does constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the State of Deficiencies. The P of Correction is prepared at executed solely because it required by the position of Federal and State Law. The Plan of Correction is submitted in order to respot to the allegation of noncompliance cited during the complaint survey conducted on January 20, 2 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, Monica Dirbas, LNHA	e not e e e e lan nd is	
F 0550 SS=D Bldg. 00	§483.10(a) Resid	Exercise of Rights lent Rights. a right to a dignified					

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

(X6) DATE

TITLE

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

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STATEMEN	NT 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		01/20/	/2022
				STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			LD HWY # 60		
SELLED	SBURG HEALTHC	ARE CENTER			RSBURG, IN 47172		
SELLEN	SBUNG HEALTHO	ARE CENTER		SELLEI	K3B0KG, IN 47 172		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	communication w	ith and access to persons					
	and services insid	le and outside the facility,					
	including those sp	pecified in this section.					
	§483.10(a)(1) A facility must treat each						
	resident with resp	ect and dignity and care for					
	each resident in a	manner and in an					
	environment that	promotes maintenance or					
	enhancement of h	nis or her quality of life,					
		resident's individuality. The					
	facility must prote	ct and promote the rights of					
	the resident.						
	§483.10(a)(2) The facility must provide equal						
	- , , , ,	care regardless of					
		y of condition, or payment					
		nust establish and					
		policies and practices					
		, discharge, and the					
		ces under the State plan for					
		rdless of payment source.					
	§483.10(b) Exerci	ise of Rights					
	- , ,	the right to exercise his or					
		sident of the facility and as					
	-	ent of the United States.					
	0.0000	The of the office office.					
	8483 10(b)(1) The	e facility must ensure that					
	. , , ,	exercise his or her rights					
		ce, coercion, discrimination,					
	or reprisal from th						
		,					
	§483.10(b)(2) The	e resident has the right to be					
	` ` ` ` `	e, coercion, discrimination,					
		the facility in exercising his					
	· ·	to be supported by the					
		cise of his or her rights as					
	required under thi	-					
	1	on, record review, and	F 0:	550	F 550 Resident Rights/Exerci	ise	02/23/2022
		ity failed to ensure resident	1 "	•	of Rights	-	=======================================

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HUF811 Facility ID: 010613

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155659		A. BUILDING <u>00</u> C		COMPL	B) DATE SURVEY COMPLETED 01/20/2022		
			- 	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			LD HWY # 60		
SELLER	SBURG HEALTHC	ARE CENTER		SELLER	RSBURG, IN 47172		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	eal preferences were honored			Corrective action for the		
		reviewed for resident rights.			residents found to have bee	n	
	(Resident L)				affected by the deficient		
					practice:		
	Findings include:				Resident L was identified as b	-	
					affected by the deficient pract	ice.	
	_	ion, on 1/20/22, at 12:11 p.m.,			Corrective action taken for		
	· ·	arsing Aide) 4 delivered			those residents having the		
		her room. Resident L was			potential to be affected by the	16	
	served ground mea	tloaf with ketchup glaze.			same deficient practice:		
	 TE1	C D :1 (I : 1			All residents have the potentia	al to	
		for Resident L was reviewed on			be affected by the deficient		
		m. Diagnoses included, but were			practice.		
		etes mellitus type 2, irritable			A review of food preferences		
	1	nuscle weakness, need for			residents has been completed		
	_	sonal care, constipation, and			ensure resident preferences a	are	
		reflux disease without			honored.		
	esophagitis.				Measures/systemic changes	put	
	TI A LATE				into place to ensure the		
		(minimum data set) assessment,			deficient practice does not		
		cated the resident was			recur:		
		had no natural teeth or tooth			The Administrator/Director of		
	_	a mechanically altered diet			Nursing/Designee held an	-4-m·	
	requiring a change	in texture of food or liquids.			in-service with nursing and die	-	
	The physician's ord	ler, dated 4/29/21, indicated the			staff to provide education and expectations as it relates to		
		lar diet with dysphagia			"Resident Rights" and providi	na	
	advanced texture, t				resident their preferred meals	-	
	auvaneca texture, t	ini consistency.			Corrective actions to be	•	
	The nutrition review	w, dated 1/19/22, indicated the			monitored to ensure the		
		dysphagia advanced diet, with			deficient practice will not		
	ground meats.	dysphagia advanced diet, with			recur:		
	Si cana mous.				The Registered Dietician/Dire	ctor	
	The Resident Profi	le on the facility's meal tracking			of Nursing/Unit Manager/	0.01	
		he resident had allergies to all			Designee will audit 5 resident	s per	
	tomatoes and toma	C			week x 4 weeks, then 3 reside	-	
	l sinus 25 una toniu	-			per week x 4 weeks, then 1		
	The resident's meal	order slip for 1/20/22 indicated			resident per week x 4 weeks	to	
		receive ground baked chicken			ensure the meal preferences		
		ch and a hamburger bun with			honored This will occur for n		

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		01/20/	/2022
		l .		CTDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	8			LD HWY # 60		
SELLED	SBURG HEALTHC	ARE CENTER			RSBURG, IN 47172		
JLLLER		TIL OLIVILIX		SLLLE			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		entree. The order slip did not			less than 3 months and		
		nt's preference for not			compliance is maintained. Any	/	
		oducts, or list any food			identified concerns will be		
	allergies for tomato	es.			immediately addressed.		
					The Director of Nursing will		
		v, on 1/19/22 at 12:29 p.m.,			present the results of these au		
		d she was supposed to get			monthly to the QAPI committe		
	_	use she had a hiatal hernia, and			for no less than 3 months. An	-	
	_	hat was not ground. She			patterns that are identified will		
	indicated it happene	ed nearly every day.			have an Action Plan initiated.		
	D	1/20/22 + 12.12			QAPI committee will determine	е	
	1	y, on 1/20/22 at 12:12 p.m.,			when 100% compliance is		
		d she couldn't eat the meatloaf.			achieved or if ongoing monitor	ring	
		omatoes or tomato products			is required.		
	1	acidic. "They know that. I've					
		d they still bring them to me all					
	the time."						
	During on interview	y, on 1/20/22 at 12:20 p.m., CNA					
	_	d been a problem the last few					
		ts not always receiving what					
		lips. They sometimes wouldn't					
		or the right drinks. Resident's					
	_	indicated what their orders					
	and preferences we						
	During an interview	y, on 1/20/22 at 2:01 p.m., the					
		etician) indicated when it came					
		sident's tray, they did not have					
		prepared for her, so she					
	_	order slip and gave the					
		atloaf instead. The sauce for					
		mato based. In the resident's					
	meal tracker, it did	not list tomatoes as an allergy,					
		o the resident that day and					
		because of digestive issues.					
		he resident was allergic to					
		as just a preference. The					
		r the meatloaf was good, but it					
		omato and she could not					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	UILDING	00	COMPL	ETED	
		155659	B. W	ING		01/20/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				LD HWY # 60		
SELLERS	BBURG HEALTHCA	ARE CENTER		SELLEF	RSBURG, IN 47172		
(X4) ID		STATEMENT OF DEFICIENCIE		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
		lent's request of not wanting n her order slip and it probably					
	should have been.	The order stip and it probably					
	should have been.						
	The Resident Rights	s policy and procedure, dated					
		1 5/30/19, provided on 1/20/22					
		ed, but was not limited to, " It					
	is the policy of this	facility to provide resident					
		eets the psychosocial,					
		onal needs and concerns of the					
		ts have a Right to Be treated					
	•	lents have the right to decide					
	_	rise in the morning, and eat					
	meals"						
	This Federal tag rela	ates to Complaint IN00371127.					
	3.1-3(a)(1)						
	3.1-3(u)(1)						
F 0610	483.12(c)(2)-(4)	1/0 / All 12/01/0					
SS=D	-	nt/Correct Alleged Violation					
Bldg. 00	- , , .	onse to allegations of ploitation, or mistreatment,					
	the facility must:	pionation, or mistreatment,					
	are radiity must.						
	§483.12(c)(2) Hav	e evidence that all alleged					
	- , , , ,	oughly investigated.					
	- , , , ,	vent further potential abuse,					
	•	on, or mistreatment while					
	the investigation is	s in progress.					
	8483 12(c)(4) Pan	ort the results of all					
	. , , , ,	ne administrator or his or					
	-	presentative and to other					
		ance with State law,					
		ate Survey Agency, within					
	_	the incident, and if the					
	alleged violation is	verified appropriate					

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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	(X3) DATE SURVEY COMPLETED 01/20/2022		
	PROVIDER OR SUPPLIER		7823 C	ADDRESS, CITY, STATE, ZIP COD DLD HWY # 60 RSBURG, IN 47172	
(VA) ID	CIDALADA	GTATEMENT OF DEFICIENCIE		1	(77.5)
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION	TAG	BEITEIRETT	DATE
	corrective action r		E 0.610	5040	02/22/2022
		on, record review, and	F 0610	F 610	02/23/2022
		ity failed to ensure a complete		Investigate/Prevent/Correct	
	_	tigation of a injury of		Alleged Violation	
	_	1 of 3 residents reviewed for		Corrective action for the	
	incident investigation	on. (Resident K)		residents found to have been	n
	F' 1' ' 1 1			affected by the deficient	
	Findings include:			practice:	
	D . 1 .	. 1/20/22 4.2.00		Resident K was identified as b	_
	_	ion, on 1/20/22 at 2:08 p.m.,		affected by the deficient practi	ice.
		served lying abed. There was a		Corrective action taken for	
		to the left knee. The bruise		those residents having the	
		green in color and surrounded		potential to be affected by the	ie
	1	e-quarters of the circumference		same deficient practice:	
	of the knee.			Residents having an injury of	
	TE 1' ' 1 1	C D '1 (17 ' 1		unknown origin have the pote	I
		for Resident K was reviewed		to be affected by the deficient	
		a.m. Diagnoses included, but		practice.	
	· · · · · · · · · · · · · · · · · · ·	, dementia without behavioral		A 30 day look back of progres	S
	_	eified mood disorder,		notes has been completed to	
	_	sions, history of transient		ensure any identified injury of	
	·	A) without residual side anxiety disorder, panic		unknown origin has been	
		n, insomnia, abnormal weight		completely and thoroughly	
	_	ralking, and need for assistance		investigated. Any identified	toly
	with personal care.	aiking, and need for assistance		concerns have been immediate	ı c ıy
	with personal care.			addressed.	nut
	The Admission MT	OS (minimum data set)		Measures/systemic changes	Put
		./12/22 indicated the resident		into place to ensure the	
		tively impaired, required		deficient practice does not	
		e of 2 plus staff for bed		recur: The Administrator/Director of	
		n room, extensive assistance of			
		and locomotion. He was not		Nursing/Designee held an in-service with nursing and die	atany
		e to stabilize with staff		_	•
	1 .			staff to provide education and	
	assistance, had no impairment to upper or lower			expectations as it relates to	og"
	extremities, and used a wheelchair. He had falls prior to admission and one fall since admission			"Occurrence Incident Reporting	iy
	•			and	
		locumented skin impairments,		Corrective actions to be	
	and did not receive	any anticoagulants.		monitored to ensure the	

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA'		(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155659	B. W	ING		01/20/	2022
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	2			LD HWY # 60		
CELLED!		ADE CENTED		1			
SELLER	SBURG HEALTHC	ARE CENTER		SELLER	RSBURG, IN 47172		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN 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'	ΓF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	The care plan, dated	d 1/6/22 and last revised on			recur:		
	1/18/22, indicated to	he resident was at risk for falls.			The Director of Nursing/Unit		
					Manager/ Designee will audit 3	3	
	The care plan, dated 1/6/22 and last revised on 1/18/22, indicated the resident was at risk for				residents per week x 4 weeks,		
					then 2 residents per week x 4		
	altered skin integrit	y. Interventions included, but			weeks, then 1 resident per we	ek x	
	were not limited to,	, complete skin at risk			4 weeks to ensure any identific	ed	
	assessment upon ad	lmission or readmission,			injury of unknown origin is		
	quarterly, and as ne	eeded.			completely and thoroughly		
					investigated. This will occur fo	r no	
	The skin/wound no	te, dated 1/6/22 at 1:33 p.m.,			less than 3 months and		
	indicated the reside	nt had a comprehensive skin			compliance is maintained. Any	,	
	and wound evaluati	on for new admission to the			identified concerns will be		
		kin with no rashes or wounds			immediately addressed.		
	identified.				The Director of Nursing will		
					present the results of these au	dits	
	The nurse's note, da	ated 1/12/22 at 4:19 p.m.,			monthly to the QAPI committe	е	
	indicated the reside	nt's family member had called			for no less than 3 months. An	y	
	the writer into the re	oom to observe a bruise on his			patterns that are identified will		
	left knee. The write	er made the DON (Director of			have an Action Plan initiated. ⁻	Γhe	
	Nursing) aware of t	the situation. The DON spoke			QAPI committee will determine	9	
		mber in person and assess the			when 100% compliance is		
		had been informed by the off			achieved or if ongoing monitor	ing	
	coming shift the res	sident had fallen on night shift.			is required.		
	I -	ot provide documentation					
	_	any investigation into the origin					
		resident's left knee, including,					
		any review of staffing					
		assessment, staff interviews					
	or statements, incid	ent report or investigation.					
		eck, dated 1/12/22 at 2:00 p.m.,					
	indicated the reside	nt had no skin impairments.					
		4.40.400					
	_	v, on 1/19/22 at 1:52 p.m., the					
	I	ember indicated he noticed the					
		te on 1/12/22 and brought it to					
	1	on. They could not tell him					
	how it happened.						

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

PRINTED: 02/16/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155659			JILDING	instruction 00	(X3) DATE (COMPL 01/20/	ETED	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7823 OLD HWY # 60 SELLERSBURG, IN 47172				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	DON indicated she family and he asked didn't see anything QMA who had been her if he had fallen, She talked to a nurs did not get any writ schedules, document there was something she would expect it. The Occurrence Increvised 5/3/18, provide RDCO included Occurrences or inciusing the Risk proteinvestigation docut the progress notes it related to a specifica. Staff will comple report in the secure describes the incide reporting, and follo Nursing or Administand provide direction required.	w, on 1/20/22 at 2:43 p.m., the had talked to the resident's differ about the bruise. She charted on it. She did talk to a moutside the room and asked and she indicated he had not. See the next day as well, but she ten statements, look at any further investigation. If greported that was unknown to be reported further up. Seident Reporting policy, last wided on 1/20/22 at 2:50 p.m., by did by the was not limited to, " dents will be investigated becolf or tier reporting and amentation will be placed in the event the information resident Level 1 Reporting Set the incident / occurrence electronic program that tent, the investigation, w-up. b. The Director of strator will review the report on for additional reporting if					
F 0684 SS=D Bldg. 00	applies to all treat facility residents.	a fundamental principle that ment and care provided to					

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Event ID:

HUF811

Facility ID: 010613

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
		IDENTIFICATION NUMBER	A. BUILDING	00	ſ ´	
AND PLAN	OF CORRECTION	155659	A. BUILDING B. WING	<u>uu</u>	COMPLETED 01/20/2022	
		100009			01/20/2022	
NAME OF I	PROVIDER OR SUPPLIER	R		ADDRESS, CITY, STATE, ZIP COD		
05.155		ADE OFAITED		DLD HWY # 60		
SELLER:	SBURG HEALTHC	ARE CENTER	SELLE	RSBURG, IN 47172		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	facility must ensu	re that residents receive				
	treatment and car	e in accordance with				
	professional stand	dards of practice, the				
	comprehensive pe	erson-centered care plan,				
	and the residents'					
		on, record review, and	F 0684	F 684 Quality of Care	02/23/2022	
	· ·	ity failed to ensure appropriate		Corrective action for the		
		entation, and follow-up		residents found to have beer	1	
	_	ise for 1 of 3 resident's		affected by the deficient		
	reviewed for Qualit	ty of Care. (Resident K)		practice:		
				Resident K was identified as b	eing	
	Findings include:			affected by the deficient practi	ce.	
				Corrective action taken for		
	-	ion, on 1/20/22 at 2:08 p.m.,		those residents having the		
		served lying abed. There was a		potential to be affected by th	е	
	-	to the left knee. The bruise		same deficient practice:		
		green in color and surrounded		Residents having a bruise		
		e-quarters of the circumference		identified have the potential to		
	of the knee.			affected by the deficient practi		
				A 30 day look back of resident	i's	
		for Resident K was reviewed		having a bruise has been		
		a.m. Diagnoses included, but		completed to ensure an		
		, dementia without behavioral		appropriate assessment,		
	_	eified mood disorder,		documentation and follow-up		
	^	sions, history of transient		monitoring of the bruise has be	een	
	· ·	(A) without residual side		completed. Any identified		
		sorder, panic disorder,		concerns have been immediat	ely	
	depression, insomn	ia, and difficulty in walking.		addressed.		
				Measures/systemic changes	put	
		OS (minimum data set)		into place to ensure the		
	· ·	/12/22 indicated the resident		deficient practice does not		
		tively impaired, required		recur:		
		e of 2 plus staff for bed		The Administrator/Director of		
		n room, extensive assistance of		Nursing/Designee held an		
		r and locomotion. He was not		in-service with nursing and die	etary	
		e to stabilize with staff		staff to provide education and		
		mpairment to upper or lower		expectations as it relates to "S		
		ed a wheelchair. He had falls		and Wound Management" with		
	prior to admission a	and one fall since admission	1	focus on appropriate assessm	ent I	

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with no injury, no documented skin impairments,

Event ID:

HUF811

Facility ID: 010613

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documentation and follow-up

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 01/20/2022 155659 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7823 OLD HWY # 60 SELLERSBURG HEALTHCARE CENTER SELLERSBURG, IN 47172 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE and did not receive any anticoagulants. monitoring of a bruise. Corrective actions to be The care plan, dated 1/6/22 and last revised on monitored to ensure the 1/18/22, indicated the resident was at risk for deficient practice will not altered skin integrity. Interventions included, but recur: were not limited to, complete skin at risk The Director of Nursing/Unit assessment upon admission or readmission, Manager/ Designee will audit 3 quarterly, and as needed. residents per week x 4 weeks, then 2 residents per week x 4 The skin/wound note, dated 1/6/22 at 1:33 p.m., weeks, then 1 resident per week x indicated the resident had a comprehensive skin 4 weeks to ensure any identified and wound evaluation for new admission to the bruise has an appropriate facility and intact skin with no rashes or wounds assessment, documentation and identified. follow-up monitoring of the bruise. This will occur for no less than 3 The nurse's note, dated 1/12/22 at 4:19 p.m., months and compliance is indicated the resident's family member had called maintained. Any identified the writer into the room to observe a bruise on his concerns will be immediately left knee. The writer made the DON (Director of addressed. Nursing) aware of the situation. The DON spoke The Director of Nursing will with the family member in person and assessed present the results of these audits the patient. monthly to the QAPI committee for no less than 3 months. Any The weekly skin check, dated 1/12/22 at 2:00 p.m., patterns that are identified will indicated the resident had no skin impairments. have an Action Plan initiated. The QAPI committee will determine The hand written physician's order, dated 1/13/22, when 100% compliance is indicated the resident had orders for a bilateral achieved or if ongoing monitoring knee X-ray to be conducted related to swelling is required. post fall. The nurse's note, dated 1/14/22 at 9:42 p.m., indicated the resident had no fracture but was noted to have infrapatellar (below the knee cap) soft tissue swelling to the left knee. The clinical record lacked documentation of any description of any bruise to the left knee including color, measurements, or pain and swelling.

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Event ID:

HUF811

Facility ID: 010613

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	LETED
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				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			LD HWY # 60		
SELLED	SBURG HEALTHC	ADE CENTED			RSBURG, IN 47172		
OLLLLIN		AND CENTER		SELLLI			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	v, on 1/19/22 at 1:52 p.m., the					
	1	ember indicated he had noticed					
		22. The bruise covered his					
	1	l was solid black and blue with					
	yellow all around it.						
		v, on 1/20/22 at 2:43 p.m., the					
		the resident's bruising it					
		nented what day it was found,					
		ing patient said about it, and					
		nts and a description of the					
		expect them to do skin					
		te sure its not getting any					
		d would expect it to be charted.					
	She hadn't seen any	thing charted on it.					
	TI CI' C 0 11	7 1M (D.1' 1)					
		Vound Management Policy, last					
	_	provided on 1/20/22 at 2:50 p.m.					
		ional Director of Clinical					
		ed, but was not limited to, "					
	_	ry team evaluates and ed skin impairments and					
		o determine the type of					
		ying conditions contributing to					
		f impairment to determine					
	_	ent Treatment b. Skin					
		entation. Complete for all skin					
	_	hat require measurements to					
	_	s occurring 6. Monitor and					
	_	9. Communicate changes to					
	the caregiving team						
	This Federal tag rel	ates to Complaint IN00371127.					
		-					
	3.1-37(a)						
F 0689	483.25(d)(1)(2)						
SS=D	Free of Accident						
Bldg. 00	Hazards/Supervis						
	§483.25(d) Accide	ents.					

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

Event ID:

HUF811 Facility ID: 010613

If continuation sheet Page 11 of 21

A BUILDING DO COMPLETED 01/20/2022 NAME OF PROVIDER OR SUPPLIER SELLERSBURG HEALTHCARE CENTER X(4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MIST BE PRECEDED BY FULL TAG PREGULATORY OR ISC IDENTIFYING INFORMATION DATE The facility must ensure that - \$483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and \$493.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure appropriate fall management, including post-fall assessment, monitoring, documentation, and investigation, for I of 3 resident's reviewed for accidents. (Resident K) Findings include: During an observation, nor I/20/22 at 2:08 p.m., Resident K was observed lying abed. There was a light, fading bruise to the left knee. The bruise was yellow to light green in color and surrounded approximately three-quarters of the circumference of the knee. The nurse's note, dated I/12/22 at 4:19 p.m., A BUILDING STREET ADDRESS, CITY, STATE, ZIP COD 7823 OLD HWY # 60 SELLERSBURG, IN 47172 ID PROVIDERS PLANDE CORRECTION. COMPLETION DATE PROVIDERS PLANDE CORRECTION. (X5) PROVIDERS PLANDE CORRECTION. PREFIX TAG PROVIDERS PLANDE CORRECTION. (X5) PROVIDERS PLANDE CORRECTION. COMPLETION DATE PROVIDERS PLANDE CORRECTION. (X5) PROVIDERS PLANDE CORRECTION. PROVIDERS PLANDE CORRECTION. (X5) PROVIDERS PLANDE CORRECTION. PROVIDERS PLANDE CORRECTION. (X5) PROVIDERS PLANDE CORRECTION. PR	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTIO		ONSTRUCTION	(X3) DATE SURVEY		
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During an observation, on 1/20/22 at 2:08 p.m., Resident K was observed lying abed. There was a light, fading bruise to the left knee. The bruise was yellow to light green in color and surrounded approximately three-quarters of the circumference of the knee. affected by the deficient practice. Corrective action taken for those residents having the potential to be affected by the same deficient practice: Residents having a fall have the potential to be affected by the deficient practice		F. 1				1 -		
During an observation, on 1/20/22 at 2:08 p.m., Resident K was observed lying abed. There was a light, fading bruise to the left knee. The bruise was yellow to light green in color and surrounded approximately three-quarters of the circumference of the knee. Corrective action taken for those residents having the potential to be affected by the same deficient practice: Residents having a fall have the potential to be affected by the deficient practice		Findings include:					_	
Resident K was observed lying abed. There was a light, fading bruise to the left knee. The bruise was yellow to light green in color and surrounded approximately three-quarters of the circumference of the knee. The bruise potential to be affected by the same deficient practice: Residents having the potential to be affected by the potential to be affected by the deficient practice		Daning on the same	:			1	ice.	
light, fading bruise to the left knee. The bruise was yellow to light green in color and surrounded approximately three-quarters of the circumference of the knee. potential to be affected by the same deficient practice: Residents having a fall have the potential to be affected by the deficient practice		_	-					
was yellow to light green in color and surrounded approximately three-quarters of the circumference of the knee. same deficient practice: Residents having a fall have the potential to be affected by the deficient practice						_		
approximately three-quarters of the circumference of the knee. Residents having a fall have the potential to be affected by the deficient practice		-				1 -	ie	
of the knee. potential to be affected by the deficient practice			-			-	ha	
deficient practice			e-quarters of the circumference			_		
		of the knee.				1 -		
The finise 8 flote, dated 1/12/22 at 7.17 p.m., A 30 day flote back of falls flas		The nurse's note do	ated 1/12/22 at 4:10 n m			1	•	
indicated the resident's family member had called been completed to ensure			-			1	٥	
the writer into the room to observe a bruise on his appropriate fall management,			-			T		
left knee. The writer made the DON (Director of including post fall assessment,						I '' '	ŀ	
Nursing) aware of the situation. The DON spoke monitoring, documentation and			*					
with the family member in person and assess the investigation has been completed.			_			_		
patient. The writer had been informed by the off Any identified concerns have been						-		
coming shift the resident had fallen on night shift.								
Measures/systemic changes put		S	·B			-	put	
The clinical record lacked documentation of any into place to ensure the		The clinical record	lacked documentation of any				14 27.2	
description of a fall, neurological checks, post fall deficient practice does not						-		
assessment, or follow-up monitoring.		_	-			-		
The Administrator/Director of		<u> </u>						
The hand written physician's order, dated 1/13/22, Nursing/Designee held an		The hand written pl	hysician's order, dated 1/13/22,					
indicated the resident had orders for a bilateral in-service with nursing and dietary							etary	
knee X-ray to be conducted related to swelling staff to provide education and						_	-	

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Event ID:

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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	JILDING	00	COMPL	ETED
		155659	B. W			01/20/	
				_			
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					LD HWY # 60		
SELLER	SBURG HEALTHC	ARE CENTER		SELLER	RSBURG, IN 47172		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	post fall.				expectations as it relates to "F	all	
					Prevention and Management		
	The nurse's note, da	ated 1/14/22 at 9:42 p.m.,			Policy" with focus on post fall		
	indicated the reside	ent had no fracture but was			assessment, monitoring,		
	noted to have infrag	patellar (below the knee cap)			documentation and investigati	on.	
	soft tissue swelling to the left knee.				Corrective actions to be		
					monitored to ensure the		
	During an interview, on 1/19/22 at 1:52 p.m., the				deficient practice will not		
	resident's family me	ember indicated he had not ever			recur:		
	been informed of th	ne resident having a fall. They			The Director of Nursing/Unit		
	had told him a nurs	e that worked on 1/11/22 had			Manager/ Designee will audit	3	
	said the resident ha	d fallen but they could not			residents per week x 4 weeks	ı	
	find any written rep	oort on it. He noticed the			then 2 residents per week x 4		
	resident had a bruise on 1/12/22, but they could				weeks, then 1 resident per we	ek x	
	not tell him how it happened.				4 weeks to ensure an appropr	iate	
					post fall assessment, monitori	ng,	
	During an interview	v, on 1/20/22 at 2:53 p.m., the			documentation and investigati	-	
	ED (Executive Dire	ector) indicated she believed the			has been completed. This will		
	DON had talked to	the resident's family a few days			occur for no less than 3 month		
	prior and the interir	n DON had been involved in a			and compliance is maintained		
	fall or something. I	f a fall was reported the facility			Any identified concerns will be		
	would start an inves	stigation immediately. There			immediately addressed.		
	should have been a	fall note on the 1/11/22 night			The Director of Nursing will		
	shift.				present the results of these au	ıdits	
					monthly to the QAPI committe	е	
	During an interview	v, on 1/20/22 at 2:41 p.m., the			for no less than 3 months. An		
	RDCO indicated sh	ne had not been able to reach			patterns that are identified will	-	
	the staff who docum	nented on 1/12/22. They had			have an Action Plan initiated.		
	talked to a nurse wh	ho they thought was the			QAPI committee will determine		
	agency staff member	er who had written the note,			when 100% compliance is		
	but she stated she h	ad never heard the resident			achieved or if ongoing monitor	ing	
	had fallen, and they	now did not believe she was			is required.	J	
		They could not determine			·		
		the wrote the note on 1/12/22.					
	_	v, on 1/20/22 at 2:43 p.m., the					
		resident had a fall, it should be					
		hould do an incident report,					
		oming shift, call the physician					
	and family. They sh	nould do an assessment, make					

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Event ID:

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AND DE LOS CONTROLLES OF THE C		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>00</u> COMPLETE	COMPLETED	
155659 B. WING 01/20/202	22	
STREET ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER 7823 OLD HWY # 60		
SELLERSBURG HEALTHCARE CENTER SELLERSBURG, IN 47172		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION	(X5)	
CROSS-REFERENCED TO THE APPROPRIATE	OMPLETION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	DATE	
sure there were no open areas, cuts, bleeding,		
bruising. Assessment would also include vital		
signs, range of motion, especially if they fell. The resident's family said something about a fall, but		
she didn't see anything charted. When she walked		
out of the room there was a QMA out there, and		
she asked her in report if they said anything about		
a fall and she said no.		
The clinical record for Resident K was reviewed		
on 1/19/22 at 10:30 a.m. Diagnoses included, but		
were not limited to, dementia without behavioral		
disturbance, unspecified mood disorder,		
unspecified convulsions, history of transient		
ischemic attack (TIA) without residual side		
deficits, anxiety disorder, panic disorder,		
depression, insomnia, abnormal weight loss, and		
difficulty in walking.		
The Admission MDS (minimum data set)		
assessment, dated 1/12/22 indicated the resident		
was severely cognitively impaired, required		
extensive assistance of 2 plus staff for bed		
mobility, walking in room, extensive assistance of		
1 staff with transfer and locomotion. He was not		
steady and only able to stabilize with staff		
assistance, had no impairment to upper or lower		
extremities, and used a wheelchair. He had falls		
prior to admission and one fall since admission		
with no injury, no documented skin impairments,		
and did not receive any anticoagulants.		
The care plan, dated 1/6/22 and last revised on		
1/18/22, indicated the resident was at risk for falls.		
Interventions included, but were not limited to,		
initiate neurological checks if fall is unwitnessed,		
or the head is involved.		
The Fall Prevention and Management policy, dated 5/25/21, provided on 1/20/22 at 1:50 p.m. by		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155659		JILDING	instruction 00	(X3) DATE : COMPL 01/20/	ETED
NAME OF PROVIDER OR SUPPLIER SELLERSBURG HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7823 OLD HWY # 60 SELLERSBURG, IN 47172					
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		d, but was not limited to, "					
	Process after a fall						
		nclude vital signs, inspection					
		ssess for any injuries, a check					
		as. The resident should be					
		pain If the resident hit their					
		witnessed fall begin					
		neurocheck policy					
	_	e the resident is safely vestigation should begin					
		omplete the 'Post Fall					
		resident suffered an injury or					
		dition complete the eInteract					
	_	n Assessment Complete the					
	-	A [assessment] every shift X					
	_	report should be initiated in					
		lisciplinary Team [IDT]					
		team should review all					
		falls the next Daily Clinical					
		should discuss the fall,					
	-	the fall, interventions put into					
	_	e effective. A deep root cause					
	_	l be discussed. The care plan					
	should be reviewed	to identify if interventions are					
		w interventions should be					
	asses. A progress no	ote of the discussion should					
	be placed in the resi						
	This Federal tag rela	ates to Complaint IN00371127.					
	3.1-45(a)						
F 0886	483.80 (h)(1)-(6)						'
SS=E		_J -Residents & Staff					
Bldg. 00	§483.80 (h) COVII	D-19 Testing. The LTC					
	- ' '	esidents and facility staff,					
	including	-					
	individuals providi	ng services under					
	_	volunteers, for COVID-19.					
	At a minimum,						

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Facility ID: 010613

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00		COMPLETED				
	155659		B. W	B. WING		01/20/2022		
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER	₹			LD HWY # 60			
SELLER	SBURG HEALTHC	ARE CENTER		1	RSBURG, IN 47172			
OLLLLIN	DONG HEALTHO	AND CENTER		JELLEI	(3B0NG, IN 47172			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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'	ΓE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	for all residents ar	nd facility staff, including						
	individuals providi	ng services under						
	arrangement							
	and volunteers, th	e LTC facility must:						
	- ',',',	onduct testing based on						
	parameters set for	rth by the Secretary,						
	including but not							
	limited to:							
	(i) Testing frequer	-						
	' '	on of any individual						
		aragraph diagnosed with						
	COVID-19 in the f							
	, ,	ion of any individual						
		aragraph with symptoms						
		OVID-19 or with known or						
	suspected exposu							
		r conducting testing of						
		ividuals specified in this						
		as the positivity rate of						
	COVID-19 in a co	•						
	• •	time for test results; and						
	` '	specified by the Secretary						
	that help identify a	· · · · · · · · · · · · · · · · · · ·						
	transmission of Co	OVID-19.						
	\$400.00 (b)/(0) C							
		onduct testing in a manner with current standards of						
		with current standards of						
	practice for conducting COVID	2.40 tooto						
		J-19 lesis,						
	8493 90 (b)(/3) Ea	or each instance of testing:						
	- ',',',	testing was completed and						
	the results of each	·						
		ne resident records that						
	testing was offere							
	appropriate	u, completeu (as						
		esting status), and the						
	results of each tes	- ,						
	Tooullo di Cacii les	J.,						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY	X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>00</u> COMPLETED	COMPLETED	
155659 B. WING 01/20/2022		
STREET ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER 7823 OLD HWY # 60		
SELLERSBURG HEALTHCARE CENTER SELLERSBURG, IN 47172		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION (X	9)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPL		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DAT	3	
§483.80 (h)((4) Upon the identification of an		
individual specified in this paragraph with		
symptoms		
consistent with COVID-19, or who tests		
positive for COVID-19, take actions to prevent		
the		
transmission of COVID-19.		
§483.80 (h)((5) Have procedures for		
addressing residents and staff, including		
individuals providing		
services under arrangement and volunteers,		
who refuse testing or are unable to be tested.		
while reliable to the unitable to be tooled.		
§483.80 (h)((6) When necessary, such as in		
emergencies due to testing supply		
shortages, contact state		
and local health departments to assist in		
testing efforts, such as obtaining testing		
supplies or		
processing test results.		
Based on record review, and interview the facility F 0886 F 886 COVID 19 Testing - 02/23	2022	
failed to ensure the clinical record contained Residents and Staff		
documentation for COVID-19 testing dates, test Corrective action for the		
results and actions to prevent the transmission of residents found to have been		
COVID-19 for 5 out of 8 residents reviewed for affected by the deficient		
documentation. (Residents C, D, G, H, and M) practice:		
Resident C was identified as being		
Findings include: affected by the deficient practice.		
Resident D was identified as being		
1. The clinical record for Resident C was reviewed, affected by the deficient practice.		
on 1/19/22 at 1:00 p.m. The diagnoses included, Not warm not limited to could hid any follows Resident H was identified as being		
but were not limited to, acute kidney failure, affected by the deficient practice.		
muscle weakness, type 2 diabetes, myocardial infarction, and stage 3 chronic kidney disease. Resident M was identified as being affected by the deficient		
infarction, and stage 3 chronic kidney disease. being affected by the deficient practice.		
լ լ իլումա-		
The Quarterly MDS (Minimum Data Set)		
The Quarterly MDS (Minimum Data Set) assessment, dated, 10/25/21, indicated the Corrective action taken for those residents having the		
The Quarterly MDS (Minimum Data Set) assessment, dated, 10/25/21, indicated the resident was moderately cognitively intact. Corrective action taken for those residents having the potential to be affected by the		

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CENTERS FOR MEDICARE & MEDICAID SERVICES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155659 B. WING 01/20/2022

STREET ADDRESS, CITY, STATE, ZIP COD

	PROVIDER OR SUPPLIER	7823 OI	7823 OLD HWY # 60				
SELLER	SBURG HEALTHCARE CENTER	SELLEF	SELLERSBURG, IN 47172				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	REGULATORY OR LSC IDENTIFYING INFORMATION The nurse's note, dated 1/10/22 at 2:31 p.m., indicated the resident was tested for outbreak testing. A rapid COVID-19 test was performed. The test results were negative. The Resident Positive Tracker Form, dated 1/13/22, indicated Resident C tested positive for COVID-19 during outbreak testing. The clinical record lacked documentation indicating the COVID-19 test dates, results of the test and action taken to prevent the transmission of COVID-19 when the resident tested positive for COVID-19 on 1/13/22. 2. The clinical record for Resident H was reviewed on 1/19/22 at 1:45 p.m. The diagnoses included, but were not limited to, acute combined systolic (congestive) and diastolic heart failure, anxiety disorder, history of COVID-19, altered mental status, and difficulty walking. The Quarterly MDS assessment, dated 10/20/21, indicated the resident was moderately cognitively intact. The nurse's note, dated 1/10/22 at 2:49 p.m., indicated the resident was tested for outbreak testing. A rapid COVID-19 test was performed. The test results were negative. The Resident Positive Tracker Form, dated 1/13/22, indicated Resident H tested positive for COVID-19 during outbreak testing. The clinical record lacked documentation		Residents requiring COVID 19 testing have the potential to be affected by the deficient practice A 30 day look back of COVID 19 resident testing has been completed for documentation of the COVID 19 testing dates, testing results and actions to prevent the transmission of COVID 19. Any identified concerns have been immediately addressed. Measures/systemic changes put into place to ensure the deficient practice does not recur: The Administrator/Director of Nursing/Designee held an in-service with nursing and dietary staff to provide education and expectations as it relates to "The Facility Testing Requirements Policy and Procedure" with focus on documentation of the COVID 19 testing dates, testing results and actions to prevent the transmission of COVID 19. Corrective actions to be monitored to ensure the deficient practice will not recur: The Director of Nursing/Unit Manager/ Designee will audit 5 residents per week x 4 weeks, then 3 residents per week x 4 weeks, then 1 resident per week x 4 weeks to ensure documentation				
	intact. The nurse's note, dated 1/10/22 at 2:49 p.m., indicated the resident was tested for outbreak testing. A rapid COVID-19 test was performed. The test results were negative. The Resident Positive Tracker Form, dated 1/13/22, indicated Resident H tested positive for COVID-19 during outbreak testing.		and actions to prevent the transmission of COVID 19. Corrective actions to be monitored to ensure the deficient practice will not recur: The Director of Nursing/Unit Manager/ Designee will audit 5 residents per week x 4 weeks, then 3 residents per week x 4 weeks, then 1 resident per week x				

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
	155659		B. W	ING		01/20	/2022
		l .		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			LD HWY # 60		
SELLEDS	SBURG HEALTHC	ARE CENTER			RSBURG, IN 47172		
JELLER	SOUNG HEALING	AND CENTER		SELLER	NODUNG, IN 47 172		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					occur for no less than 3 month	าร	
		rd for Resident G was reviewed,			and compliance is maintained		
		p.m. The diagnoses included,			Any identified concerns will be	•	
	but were not limited	-			immediately addressed.		
		xia, colostomy, muscle					
		of a kidney, cognitive					
		icit, nausea and absence of the					
	left and right hand.						
		S assessment, dated 8/2/21,					
	indicated the reside	ent was cognitively intact.					
	TI 11/10/02 + 2.50						
	The nurse's note, dated 1/10/22 at 3:59 p.m.,						
	indicated the resident was tested for outbreak						
	testing. A rapid COVID-19 test was performed. The test results were negative.						
	The test results wer	e negative.					
	The Resident Positi	ive Tracker Form, dated					
	The Resident Positive Tracker Form, dated 1/13/22, indicated Resident G tested positive for						
	COVID-19 during	-					
	CO (ID 1) during	outoreak testing.					
	The clinical record	lacked documentation					
		TD-19 test dates, results of the					
	_	n to prevent the transmission					
		en the resident tested positive					
	for COVID-19 on 1	-					
	4. The clinical reco	rd for Resident M was					
	reviewed, on 1/19/2	22 at 1:45 p.m., the diagnoses					
	included, but were	not limited to, hemiplegia and					
	hemiparesis follow	ing cerebral infarction, chronic					
	obstructive pulmon	ary disease with exacerbation,					
	type 2 diabetes, COVID-19, hypertension, and						
	atrial fibrillation.						
		S assessment, dated 1/6/22,					1
	indicated the reside	ent was moderately intact.					
		. 11/10/02 2.50					
		ated 1/10/22 at 3:59 p.m.,					
	L indicated the recide	nt was tested for outbreak	1		I		i .

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155659		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 01/20/2022			
NAME OF PROVIDER OR SUPPLIER SELLERSBURG HEALTHCARE CENTER		7823 O	ADDRESS, CITY, STATE, ZIP COD PLD HWY # 60 RSBURG, IN 47172		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE COMPLETION
TAG		VID-19 test was performed. e positive.	TAG	DEFICIENCY	DATE
		lacked documentation 1 taken to prevent the VID-19.			
	on 1/19/22 at 3:30 p but were not limited	rd for Resident D was reviewed, o.m. The diagnoses included, I to, type 2 diabetes, congestive heart failure and			
		S assessment, dated 1/7/222, nt was cognitively intact.			
	indicated the reside	nted 1/10/22 at 2:31 p.m., nt was tested for outbreak VID-19 test was performed. e negative.			
		ve Tracker Form, dated Resident D tested positive for outbreak testing.			
	indicating the COV test and action takes	lacked documentation ID-19 test dates, results of the n to prevent the transmission the resident tested positive on			
	Regional Director of indicated document located under the U assessments) assess monitoring would be (Medication Admin	ments, and COVID symptom be completed on the MAR istration Record) for the order ing or under a UDA			

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

PRINTED: 02/16/2022 FORM APPROVED OMB NO. 0938-039

	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 01/20/2022	
NAME OF PROVIDER OR SUPPLIER SELLERSBURG HEALTHCARE CENTER			7823 O	ADDRESS, CITY, STATE, ZIP COD LD HWY # 60 RSBURG, IN 47172			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IATE	(X5) COMPLETION DATE
	During an interview, on 1/20/22 at 1:35 p.m., the DON (Director of Nursing) indicated when a resident tested positive for COVID-19 the test results, date of test, and what action was taken should be documented in the clinical record by the nursing staff. The Facility Testing Requirements policy and procedure, last revised 5/4/21, provided on 1/19/22 at 9:35 a.m. by the RDCO, included, but was not limited to,"1. For symptomatic residents and staff, document the date(s) and time(s) of the identification of the sign and symptoms, when testing was conducted, when results were obtained, and the actions the facility took based on the results"						

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