PRINTED: 10/25/2024 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDI	CAID SERVICES			OM	B NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155659		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 00 COMPLETED B. WING 09/26/2024				
NAME OF I	PROVIDER OR SUPPLIE	in the second se		ADDRESS, CITY, STATE, ZIP COD VLD STATE ROAD 60		
SELLER	SBURG HEALTHO	CARE CENTER	SELLE	RSBURG, IN 47172		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE CNCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
F 0000						
Bldg. 00	IN00442515. Complaint IN0044	the Investigation of Complaint 42515 - Federal/State deficiencies gations are cited at F684, F690	F 0000			
	Survey dates: Sep	otember 24, 25 and 26, 2024				
	Facility number: Provider number: AIM number: 200	155659				
	Census Bed Type: SNF/NF: 99 Total: 99					
	Census Payor Typ Medicare: 13 Medicaid: 78 Other: 8 Total: 99	e:				
	These deficiencies accordance with 4	s reflect State Findings cited in 10 IAC 16.2-3.1.				
	Quality review co	mpleted on October 2, 2024.				
F 0684 SS=D Bldg. 00	483.25 Quality of Care					
Ŭ	failed to ensure an was implemented	w and record review, the facility n increase in free water flushes (Resident B) and failed to ensure ameters for blood pressure	F 0684	F684 Preparation or execution of this plan of correction does in constitute admission or	not	10/31/2024

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

medication administration (Resident D) for 2 of 3

residents reviewed for quality of care.

William Jackson

TITLE

agreement of provider of the

truth of the facts alleged or

10/16/2024

(X6) DATE

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

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Administrator

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER					(X3) DATE SU	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLET	TED
		155659	B. W	ING		09/26/2	024
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
051155		A DE OENTED			LD STATE ROAD 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	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	·	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					conclusions set forth on the		
	Findings include:				State of Deficiencies. The Plan	an	
					of Correction is prepared an	d	
	1. The clinical reco	rd for Resident B was reviewed			executed solely because it is		
	on 9/24/24 at 10:08	a.m. The resident's diagnosis			required by the position of		
	included, but was n	ot limited to, gastrostomy			Federal and State Law.		
	status.	, ,			The Plan of Correction is		
The physician's order, dated 7/9/24, indicated to				submitted in order to respon	d l		
	The physician's ord	er, dated 7/9/24, indicated to			to the allegation of		
					noncompliance cited during		
status.				the complaint survey			
	,	,			conducted on September 24		
	The resident's labor	ratory report, dated 7/15/24.			25, 26 2024 Please accept the		
					plan of correction as the	.	
		` ,			provider's credible allegation	n	
		<u> </u>			of compliance.		
					The facility would like to		
	_	<i>S</i> 1			respectfully request a desk		
	1 3				review.		
	The nurse practition	ner note, dated 7/16/24,			William Jackson HFA		
		e the resident's free water					
	flushes to 40 cc's (c	subic centimeters) every hour.			STEP 1 Corrective action for		
	· ·	, ,			the residents found to have		
	The clinical record	lacked documentation of an			been affected by the deficier	nt	
	order to increase the	e resident's free water dosage			practice:		
		e free water flushes to 40 ml.					
					/p>		
	During an interview	on 9/26/24 at 1:55 p.m., the					
		indicated the nurse			STEP 2 Corrective action tak	en	
	_	ponsible for putting the order			for those residents having th	-	
	_	d have been put in the system			potential to be affected by th		
		tioner did not enter them into			same deficient practice:		
	the system.						
					All residents who have orders	with	
	2. The clinical reco	rd for Resident D was reviewed			blood pressure parameters or		
		a.m. The diagnosis included,			medications/g-tube patients co		
		to, orthostatic hypotension.			be affected by the alleged def		
					practice. A 30- day lookback of		
	The physician's ord	er, dated 7/16/24, indicated the			medications with blood pressu		
	resident was to rece				parameters was completed to	•	
	i		1		1 '		

10/25/2024 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 09/26/2024 155659 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7823 OLD STATE ROAD 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 (hydrochloride) 10 mg (milligrams) three times a ensure medications had been day at 8:00 a.m., 12:00 p.m. and 5:00 p.m. for low administered according to blood pressure. The medication was to be held for physician orders. A 30-day a systolic blood pressure (SBP) greater than 120. lookback of all residents with G-Tube completed to ensure all Review of the August 2024 medication flush orders are correct. Any administration record indicated the resident identified concerns were received the medication as follows: immediately addressed. -8/03/24 at 5:00 p.m. with a SBP of 121 -8/06/24 at 12 p.m. with a SBP of 121 STEP 3 Measures/systemic -8/07/24 at 12 p.m. with a SBP of 122 and at 5:00 changes put into place to p.m. with a SBP of 124 ensure the deficient practice -8/08/24 at 8:00 a.m. with a SBP of 126; 12 p.m. with does not recur: SBP of 123 and 5:00 p.m. with a SBP of 128 The DNS/Designee held an -8/11/24 at 12 p.m. with a SBP of 121 and at 5:00 in-service for all nurses to provide p.m. with a SBP of 129 education and expectations as it -8/14/24 at 8:00 a.m. with a SBP of 121 relates to the "medication -8/17/24 at 12 p.m. with a SBP of 127 and at 5:00 administration" policy and p.m. with a SBP of 121 procedures including administering -8/21/24 at 8:00 a.m. with a SBP of 121 and at 12 blood pressure medications with p.m. with a SBP of 129 parameters according to physician -8/23/24 at 8:00 a.m. with a SBP of 129 orders. The DNS/Designee held an -8/28/24 at 8:00 a.m. with a SBP of 121 in-service for all nurses to provide -8/29/24 at 5:00 p.m. with a SBP of 121 education and expectations as it relates to compliance with Review of the the September 2024 medication following physician flush orders. administration record indicated the resident received the medication as follows: STEP 4 Corrective actions to be -9/01/24 at 5:00 p.m. with a SBP of 121 monitored to ensure the -9/02/24 at 12 p.m. with a SBP of 132 deficient practice will not -9/06/24 at 8:00 a.m. with a SBP of 122 recur: -9/09/24 at 5:00 p.m. with a SBP of 121 -9/12/24 at 8:00 a.m. with a SBP of 125 The DNS/designee will audit 5 -9/14/24 at 12 p.m. with a SBP of 121 and 5:00 p.m. residents a weeks x 4 weeks. with a SBP of 122 then 3 residents a week x 4

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-9/17/24 at 12 p.m. with a SBP of 122

-9/18/24 at 12 p.m. with a SBP of 122

a SBP of 128; 5:00 p.m. with a SBP of 125

-9/20/24 at 8:00 a.m. with a SBP of 122; 12 p.m. with

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weeks, then 1 resident a week x 4

weeks for no less than 3 months

and compliance is maintained to

ensure blood pressure medication with parameters are administered

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155659	B. WI	NG		09/26/	2024
	ROVIDER OR SUPPLIER			7823 OI	ADDRESS, CITY, STATE, ZIP COD LD STATE ROAD 60 RSBURG, IN 47172		
(X4) ID PREFIX	(EACH DEFICIEN	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 APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION
TAG	During an interview (Registered Nurse) a parameters should a On 9/26/24 at 2:45 provided a current, titled "Medication A but was not limited this facility to provicareProcedureA prescribed by the pr	o.m., the Director of Nursing undated copy of the document administration". It included, to, "PolicyIt is the policy of de resident centered dminister medication only as		TAG	per physician order. The DNS/designee will audit 5 residents a weeks x 4 weeks, then 3 residents a week x 4 weeks, then 1 resident a week weeks for no less than 3 month and compliance is maintained ensure all flush orders are followed. The Administrator/Designee w present the results of these au monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. QAPI committee will determine when 100% compliance is achieved or if ongoing monitor is required.	x 4 hs to ill dits e y	DATE
F 0690 SS=D Bldg. 00	Based on interview failed to implement resident (Resident E residents reviewed for Findings include: The clinical record to on 9/24/24 at 10:08 included, but were residents reviewed for the clinical record to the clinical record	and record review, the facility Indwelling catheter care for a b), upon readmission, for 1 of 3 for Indwelling catheters. For Resident B was reviewed a.m. The resident's diagnoses not limited to, cerebral meningitis, gastrostomy stention.	F 06	590	F690 Preparation or execution of this plan of correction does reconstitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the State of Deficiencies. The Plate of Correction is prepared and executed solely because it is required by the position of Federal and State Law.	ın İ	10/31/2024

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Event ID:

KRLI11

Facility ID: 010613

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	JILDING	00	COMPLETED	
		155659	B. W	ING		09/26/2024
				CTREET	ADDRESS CITY STATE ZID COD	
NAME OF P	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD	
051155	SELLERSBURG HEALTHCARE CENTER				LD STATE ROAD 60	
SELLERS	SBURG HEALTHCA	ARE CENTER		SELLE	RSBURG, IN 47172	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DE CLUDERIS N. AN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
					The Plan of Correction is	
	The care plan dated	1 7/5/24, indicated the resident			submitted in order to respon	d
	* .	atheter and staff were to			-	u
	_				to the allegation of	
	provide catheter car	e every sinit.			noncompliance cited during	
	TT 1	1 . 10/16/24 . 7 20			the complaint survey	
		dated 8/16/24 at 7:30 p.m.,			conducted on September 24,	
		B was sent to the emergency			25, 26 2024 Please accept thi	S
		. Resident B was readmitted to			plan of correction as the	
	the facility on 8/24/	24 at 5:00 p.m.			provider's credible allegation	1
					of compliance.	
		and physical, dated 8/16/24,			The facility would like to	
	indicated Resident I	B had chronic urinary			respectfully request a desk	
	retention, an indwel	ling catheter was in place			review.	
	which was changed	. The resident's indwelling			William Jackson HFA	
	catheter was replace	ed during the resident's				
	hospital stay.	_			STEP 1 Corrective action for	
					the residents found to have	
	The clinical record	lacked documentation of the			been affected by the deficien	ıt İ
		g catheter care on 8/25/24 and			practice:	
		sident's readmission to the			pruotioo.	
	facility.	sident's readingsion to the			/p>	
	lacinty.				/p-	
	During an interview	on 9/26/24 at 3:00 p.m., RN			STEP 2 Corrective action tak	on
	_	5 indicated a resident's				
					for those residents having the	
	_	care should be implemented			potential to be affected by th	e
	upon admission.				same deficient practice:	
	Th	duration sixted HCod 4 - C - H			All manifesters to the second	
		d policy titled "Catheter Care"			All residents who have newly	
		ot limited to, "PolicyIt is the			admitted could be affected by	
		y to provide resident care that			alleged deficient practice. A 30)-
	meets thephysical				day lookback of all new admit	
		are is performed at least twice			residents to ensure all cathete	
	daily on residents th	nat have indwelling			care orders were entered upor	n
	catheters"				admission without delay. Any	
					identified concerns were	
	This Citation relates	s to Complaint IN00442515			immediately addressed.	
]	
	3.1-41(a)				STEP 3 Measures/systemic	
					changes put into place to	
					ensure the deficient practice	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FO	R MEDICARE & MEDIC	AID SERVICES			OM	B NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED		
		155659	B. WING		09/26/	2024	
NAME OF	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD			
051155		ADE OFNITED		DLD STATE ROAD 60			
SELLER	RSBURG 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 APPROPRIATE	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
				does not recur:			
				The DNS/Designee held an			
				in-service for all nurses to prov	/ide		
				education and expectations as			
				relates to the "Catheter Care"			
				policy and procedures includin	g l		
				catheter care orders entered u			
				admission to facility without de			
				STEP 4 Corrective actions to	be		
				monitored to ensure the			
				deficient practice will not			
				recur:			
				The DNS/designee will audit 5			
				residents a weeks x 4 weeks,			
				then 3 residents a week x 4			
				weeks, then 1 resident a week	x 4		
				weeks for no less than 3 month	hs		
				and compliance is maintained	to		
				ensure catheter care orders ar	e e		
				entered upon admission to fac	ility		
				without delay.			
				The Administrator/Designee w			
				present the results of these au			
				monthly to the QAPI committee			
				for no less than 3 months. Any	у		
				patterns that are identified will			
				have an Action Plan initiated.			
				QAPI committee will determine	•		
				when 100% compliance is			
				achieved or if ongoing monitor	ing		
				is required.			
E 0770	400 50()(4)()						
F 0770 SS=D	483.50(a)(1)(i)						

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

Bldg. 00

Event ID:

Based on interview and record review, the facility

failed to implement a laboratory order for a

KRLI11

F 0770

Facility ID: 010613

Preparation or execution of

F770

If continuation sheet

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OMI	B NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED		
11112 121111	or condition	155659	B. W		00	09/26/		
		133039	B. W			09/20/	2024	
NAME OF I	DOLUBED OF CLUBNIES			STREET .	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	C		7823 O	OLD STATE ROAD 60			
SELLERS	SBURG HEALTHCA	ARE CENTER		SELLE	RSBURG, IN 47172			
	Г		-			ı		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	resident (Resident I	3) for 1 of 3 residents reviewed			this plan of correction does	not		
	for laboratory servi-	ces.			constitute admission or			
	•				agreement of provider of the			
	Findings include:				truth of the facts alleged or			
					conclusions set forth on the			
	The clinical record	for Resident R was reviewed			State of Deficiencies. The Pla	n		
		The clinical record for Resident B was reviewed on 9/24/24 at 10:08 a.m. The resident's diagnoses						
		not limited to, cerebral			of Correction is prepared and			
	· · · · · · · · · · · · · · · · · · ·				executed solely because it is	•		
	infarction, respirato	ory failure and hypercalcemia.			required by the position of			
	l				Federal and State Law.			
	_	ner note, dated 7/16/24 at 8:00			The Plan of Correction is			
	a.m., indicated to obtain a BMP (basic metabolic				submitted in order to respon	d		
	l - ·	ue to elevated calcium level of			to the allegation of			
	10.9 (normal range	was 8.5 to 10.2).			noncompliance cited during			
					the complaint survey			
	The nurse practition	ner note, dated 7/19/24 at 8:15			conducted on September 24	,		
	a.m., indicated the l	BMP needed to be obtained.			25, 26 2024 Please accept thi	is		
					plan of correction as the			
	The clinical record	lacked documentation of the			provider's credible allegation	n		
	BMP requested by	the nurse practitioner.			of compliance.			
		•			The facility would like to			
	During an interview	v on 9/26/24 at 1:55 p.m., the			respectfully request a desk			
	1	; indicated the nurse			review.			
		ponsible for putting the lab			William Jackson HFA			
	1 ~	should have been put in the			Triniani Gackson III A			
		se practitioner did not enter			STEP 1 Corrective action for			
	them into the system	-						
	mem mio me system	II.			the residents found to have			
	On 0/26/24 -+ 2:45	n me the Dinecton - £NIi			been affected by the deficier	IL		
	I	p.m., the Director of Nursing			practice:			
	_	undated copy of the document						
	-	and Radiological Services and			/p>			
		It included, but was not						
		.It is the policy of this facility			STEP 2 Corrective action tak			
		centered care that meets			for those residents having th			
		lsof the residentsThe			potential to be affected by th	е		
		laboratoryservices that meet			same deficient practice:			
	the needs of the res	ident"						
					All residents who receive lab			
	This Citation relates	s to Complaint IN00442515			orders per MD could be affect	ed		

by the alleged deficient practice. A

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

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLE	ETED
		155659	B. W	ING		09/26/2	2024
				CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			LD STATE ROAD 60		
SELLERS	SBURG HEALTHC	ARE CENTER			RSBURG, IN 47172		
OLLLLIN	SBOILD HEALTHO	ARE OLIVIER		OLLLL			
(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	.TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	3.1-49(a)				30- day lookback of all labs to		
					ensure all lab orders were		
					completed per MD order. Any		
					identified concerns were		
					immediately addressed.		
					STEP 3 Measures/systemic		
					changes put into place to		
					ensure the deficient practice	!	
					does not recur:		(X5) COMPLETION
					The DNS/Designee held an		
					in-service for all staff to provid		
					education and expectations as		
					relates to the "Laboratory and		
					Radiological Services and Res		
					Reporting" policy and procedu		
					as it relates to completing all la	abs	
					per MD order.		
					STEP 4 Corrective actions to	, ha	
					monitored to ensure the	, pe	
					deficient practice will not		
					recur:		
					10041.		
					The DNS/designee will observ	_{/e.5}	
					staff members a weeks x 4		
					weeks, then 3 staff members	a	
					week x 4 weeks, then 1 staff	-	
					member a week x 4 weeks for	. _{no}	
					less than 3 months and		
					compliance is maintained to		
					ensure all lab orders were		
					completed per MD order.		
					, , , , , , , , , , , , , , , , , , , ,		
					The Administrator/Designee w	/ill	
					present the results of these au		
					monthly to the QAPI committee		
					for no less than 3 months. An		
					patterns that are identified will	-	
					have an Action Plan initiated.		

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Event ID:

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If continuation sheet

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII	LDING	00	COMPL	COMPLETED	
		155659	B. WIN	G		09/26/	/2024	
NAME OF PROVIDER OR SUPPLIER SELLERSBURG HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 7823 OLD STATE ROAD 60 SELLERSBURG, IN 47172				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					QAPI committee will determine when 100% compliance is achieved or if ongoing monitor is required.			

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