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	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SELLERSBURG HEALTHCARE CENTER	7823 OLD STATE ROAD 60 SELLERSBURG, IN 47172

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00442515. Complaint IN00442515 - Federal/State deficiencies related to the allegations are cited at F684, F690 and F770. Survey dates: September 24, 25 and 26, 2024 Facility number: 010613 Provider number: 155659 AIM number: 200221040 Census Bed Type: SNF/NF: 99 Total: 99 Census Payor Type: Medicare: 13 Medicaid: 78 Other: 8 Total: 99 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 2, 2024.	F 0000		
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to ensure an increase in free water flushes was implemented (Resident B) and failed to ensure staff followed parameters for blood pressure medication administration (Resident D) for 2 of 3 residents reviewed for quality of care.	F 0684	**F684** **Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or**	10/31/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
William Jackson	Administrator	10/16/2024

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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	Findings include: 1. The clinical record for Resident B was reviewed on 9/24/24 at 10:08 a.m. The resident's diagnosis included, but was not limited to, gastrostomy status. The physician's order, dated 7/9/24, indicated to flush the resident's feeding tube with 30 ml (milliliters) of free water every hour. The resident's laboratory report, dated 7/15/24, indicated the resident's BUN (blood urea nitrogen) test result was elevated at 31 mg/dl (normal 10 mg/dl to 20mg/dl). A higher than 20 mg/dl suggest that the kidneys may not be functioning at optimal capacity. The nurse practitioner note, dated 7/16/24, indicated to increase the resident's free water flushes to 40 cc's (cubic centimeters) every hour. The clinical record lacked documentation of an order to increase the resident's free water dosage or an increase of the free water flushes to 40 ml. During an interview on 9/26/24 at 1:55 p.m., the Director of Nursing indicated the nurse practitioner was responsible for putting the order in. The order should have been put in the system and the nurse practitioner did not enter them into the system. 2. The clinical record for Resident D was reviewed on 9/25/24 at 10:01 a.m. The diagnosis included, but was not limited to, orthostatic hypotension. The physician's order, dated 7/16/24, indicated the resident was to receive Midodrine HCl		**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 conducted on September 24, 25, 26 2024 Please accept this plan of correction as the provider's credible allegation of compliance.** **The facility would like to respectfully request a desk review.** **William Jackson HFA** **STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** /p> **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who have orders with blood pressure parameters or medications/g-tube patients could be affected by the alleged deficient practice. A 30- day lookback of all medications with blood pressure parameters was completed to	

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	(hydrochloride) 10 mg (milligrams) three times a day at 8:00 a.m., 12:00 p.m. and 5:00 p.m. for low blood pressure. The medication was to be held for a systolic blood pressure (SBP) greater than 120. Review of the August 2024 medication administration record indicated the resident received the medication as follows: -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 -8/07/24 at 12 p.m. with a SBP of 122 and at 5:00 p.m. with a SBP of 124 -8/08/24 at 8:00 a.m. with a SBP of 126; 12 p.m. with SBP of 123 and 5:00 p.m. with a SBP of 128 -8/11/24 at 12 p.m. with a SBP of 121 and at 5:00 p.m. with a SBP of 129 -8/14/24 at 8:00 a.m. with a SBP of 121 -8/17/24 at 12 p.m. with a SBP of 127 and at 5:00 p.m. with a SBP of 121 -8/21/24 at 8:00 a.m. with a SBP of 121 and at 12 p.m. with a SBP of 129 -8/23/24 at 8:00 a.m. with a SBP of 129 -8/28/24 at 8:00 a.m. with a SBP of 121 -8/29/24 at 5:00 p.m. with a SBP of 121 Review of the the September 2024 medication administration record indicated the resident received the medication as follows: -9/01/24 at 5:00 p.m. with a SBP of 121 -9/02/24 at 12 p.m. with a SBP of 132 -9/06/24 at 8:00 a.m. with a SBP of 122 -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 -9/14/24 at 12 p.m. with a SBP of 121 and 5:00 p.m. with a SBP of 122 -9/17/24 at 12 p.m. with a SBP of 122 -9/18/24 at 12 p.m. with a SBP of 122 -9/20/24 at 8:00 a.m. with a SBP of 122; 12 p.m. with a SBP of 128; 5:00 p.m. with a SBP of 125		ensure medications had been administered according to physician orders. A 30-day lookback of all residents with G-Tube completed to ensure all flush orders are correct. Any identified concerns were immediately addressed. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The DNS/Designee held an in-service for all nurses to provide education and expectations as it relates to the “medication administration” policy and procedures including administering blood pressure medications with parameters according to physician orders. The DNS/Designee held an in-service for all nurses to provide education and expectations as it relates to compliance with following physician flush orders. **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 months and compliance is maintained to ensure blood pressure medication with parameters are administered	

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	During an interview on 9/26/24 at 2:34 p.m., RN (Registered Nurse) 7 indicated medication parameters should always be followed. On 9/26/24 at 2:45 p.m., the Director of Nursing provided a current, undated copy of the document titled "Medication Administration". It included, but was not limited to, "Policy...It is the policy of this facility to provide resident centered care...Procedure...Administer medication only as prescribed by the provider...." This Citation relates to Complaint IN00442515 3.1-37		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 x 4 weeks for no less than 3 months and compliance is maintained to ensure all flush orders are followed. The Administrator/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.	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on interview and record review, the facility failed to implement Indwelling catheter care for a resident (Resident B), upon readmission, for 1 of 3 residents reviewed for Indwelling catheters. Findings include: The clinical record for Resident B was reviewed on 9/24/24 at 10:08 a.m. The resident's diagnoses included, but were not limited to, cerebral infarction, bacterial meningitis, gastrostomy status and urinary retention.	F 0690	**F690** **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.**	10/31/2024

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	The care plan, dated 7/5/24, indicated the resident had an indwelling catheter and staff were to provide catheter care every shift. The progress noted, dated 8/16/24 at 7:30 p.m., indicated Resident B was sent to the emergency room for evaluation. Resident B was readmitted to the facility on 8/24/24 at 5:00 p.m. The hospital history and physical, dated 8/16/24, indicated Resident B had chronic urinary retention, an indwelling catheter was in place which was changed. The resident's indwelling catheter was replaced during the resident's hospital stay. The clinical record lacked documentation of the resident's indwelling catheter care on 8/25/24 and 8/26/24, after the resident's readmission to the facility. During an interview on 9/26/24 at 3:00 p.m., RN (Registered Nurse) 5 indicated a resident's indwelling catheter care should be implemented upon admission. The current, undated policy titled "Catheter Care" included, but was not limited to, "Policy...It is the policy of this facility to provide resident care that meets the...physical...needs...of the resident...Catheter care is performed at least twice daily on residents that have indwelling catheters...." This Citation relates to Complaint IN00442515 3.1-41(a)		**The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the complaint survey conducted on September 24, 25, 26 2024 Please accept this plan of correction as the provider's credible allegation of compliance.** **The facility would like to respectfully request a desk review.** **William Jackson HFA** **STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** /p> **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who have newly admitted could be affected by the alleged deficient practice. A 30-day lookback of all new admit residents to ensure all catheter care orders were entered upon admission without delay. Any identified concerns were immediately addressed. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice**	

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			does not recur: The DNS/Designee held an in-service for all nurses to provide education and expectations as it relates to the “Catheter Care” policy and procedures including catheter care orders entered upon admission to facility without delay. **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 months and compliance is maintained to ensure catheter care orders are entered upon admission to facility without delay. The Administrator/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.	
F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services Based on interview and record review, the facility failed to implement a laboratory order for a	F 0770	**F770** **Preparation or execution of**	10/31/2024

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	resident (Resident B) for 1 of 3 residents reviewed for laboratory services. Findings include: The clinical record for Resident B was reviewed on 9/24/24 at 10:08 a.m. The resident's diagnoses included, but were not limited to, cerebral infarction, respiratory failure and hypercalcemia. The nurse practitioner note, dated 7/16/24 at 8:00 a.m., indicated to obtain a BMP (basic metabolic panel) on 7/19/24 due to elevated calcium level of 10.9 (normal range was 8.5 to 10.2). The nurse practitioner note, dated 7/19/24 at 8:15 a.m., indicated the BMP needed to be obtained. The clinical record lacked documentation of the BMP requested by the nurse practitioner. During an interview on 9/26/24 at 1:55 p.m., the Director of Nursing indicated the nurse practitioner was responsible for putting the lab order in. The order should have been put in the system and the nurse practitioner did not enter them into the system. On 9/26/24 at 2:45 p.m., the Director of Nursing provided a current, undated copy of the document titled "Laboratory and Radiological Services and Results Reporting". It included, but was not limited to, "Policy...It is the policy of this facility to provide resident centered care that meets the...physical...needs...of the residents...The facility will secure laboratory...services that meet the needs of the resident...." This Citation relates to Complaint IN00442515		**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 conducted on September 24, 25, 26 2024 Please accept this plan of correction as the provider's credible allegation of compliance.** **The facility would like to respectfully request a desk review.** **William Jackson HFA** **STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** /p> **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who receive lab orders per MD could be affected by the alleged deficient practice. A	

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	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:** The DNS/Designee held an in-service for all staff to provide education and expectations as it relates to the "Laboratory and Radiological Services and Results Reporting" policy and procedures as it relates to completing all labs per MD order. **STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:** The DNS/designee will observe 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 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	

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