STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155659		X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  X3) DATE SURVEY  COMPLETED  10/29/2024			
	PROVIDER OR SUPPLIER		7823	ET ADDRESS, CITY, STATE, ZIP COD OLD STATE ROAD 60 LERSBURG, IN 47172	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
E 0000					
Bldg			E 0000		
	Facility Number: 0 Provider Number: 2002	155659			
	Sellersburg Healthc compliance with En Requirements for M	Preparedness survey, are Center was found in nergency Preparedness ledicare and Medicaid lers and Suppliers, 42 CFR			
	The facility has 110 the survey, the cens	certified beds. At the time of us was 90.			
	Quality Review con	npleted on 10/30/24			
K 0000					
Bldg. 01	Licensure Survey w	Recertification and State as conducted by the Indiana th in accordance with 42 CFR	K 0000		
	Facility Number: 0 Provider Number: 2002	10613 155659			
	At this Life Safety (	Code survey, Sellersburg			
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE

William Jackson Administrator 11/11/2024

Any definency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin

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 disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: ND1X21 Facility ID: 010613 If continuation sheet Page 1 of 12

PRINTED: 11/15/2024 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155659	CIFICATION NUMBER A. BUILDING <u>01</u>		(X3) DATE SURVEY COMPLETED 10/29/2024	
	PROVIDER OR SUPPLIER SBURG HEALTHCA		7823 C	ADDRESS, CITY, STATE, ZIP COD DLD STATE ROAD 60 RSBURG, IN 47172		
(X4) ID PREFIX TAG	REGULATORY OF Healthcare Center with Requirements Medicare/Medicaid Life Safety from Fi National Fire Protect Life Safety Code (I Health Care Occupa This one story facil Type V (111) const The facility has a fi detection in the corr corridors, and hard resident sleeping ro that alarm at the cer facility has 15 total The facility has a ca census of 90 at the All areas where resi were sprinkled and services were sprinkled and services were sprinkled.	ity was determined to be of ruction and fully sprinkled. re alarm system with smoke ridors, spaces open to the wired smoke detectors in all oms with a battery backup intral nurse's station. The vent unit beds in the 400 Hall. apacity of 110 and had a	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (X5) COMPLETION DATE	
SS=E Bldg. 01	failed to ensure 1 or arrangements was in LSC 7.2.1.6.1(3) who process shall release egress within 15 sea approved by the aut upon application of	on and Interview, the facility f over 7 delayed egress locking installed in accordance with hich states an irreversible the lock in the direction of conds, or 30 seconds where thority having jurisdiction, a force to the release device	K 0222	K 222  Preparation or execution of this plan of correction does a constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the State of		

conditions:

Deficiencies. The Plan of

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	01	COMPLETED		
		155659	B. W	B. WING 10/29/2024				
NAME OF T	DROWINED OF CURPLUE			STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	•		7823 OLD STATE ROAD 60				
SELLERS	SBURG HEALTHCA	ARE CENTER		SELLERSBURG, 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)			
TAG		a LSC IDENTIFYING INFORMATION not be required to exceed 15 lbf		TAG	Correction is prepared and	DATE		
	(67 N).	for be required to exceed 13 for			executed solely because it is			
	` '	not be required to be			required by	•		
	, ,	d for more than 3 seconds.			the position of Federal and			
		the release process shall			State Law.			
		signal in the vicinity of the			The Plan of Correction is			
	door opening.				submitted in order to respon	nd		
	· ·	as been released by the			to the allegation of			
	* *	to the releasing device,			noncompliance			
	_	y manual means only. This			cited during the Life Safety			
	deficient practice co	ould affect 8 staff.			Annual Survey conducted or	n		
					October 29th, 2024 . Please			
	Findings include:				accept this plan of correction	n		
	D 1 1	11 7 1 24 4			as the provider's credible			
		on and interview with the			allegation of compliance.			
		for (MD) on 10/29/24 during a petween 11:30 a.m. and 1:35			The facility would like to			
	-	it door was equipped with a 15			respectfully request a desk review.			
	_	ess. When the exit door was			William Jackson HFA			
		le process to release the lock			William Sackson in A			
		ased on interview at the time of			STEP 1 Corrective action for	•		
		O tried 3 times to activate the			the residents found to have			
		ID stated the delayed egress			been affected by the deficier	nt		
		vever it was working when he			practice:			
	checked it recently	but now will need to be			Residents were not harmed b	y the		
	repaired.				alleged deficient practice.			
	This finding was re	viewed with the Maintenance			STEP 2 Corrective action tak	ken		
		tive Director during the exit			for those residents having th			
	conference.				potential to be affected by th	ne		
					same deficient practice:			
	3.1-19(b)				Maintenance repaired kitchen			
					with 15 second egress restore	ed.		
					STEP 3 Measures/systemic			
					changes put into place to			
					ensure the deficient practice	•		
					does not			
					recur:			
					The Executive Director held in	n		

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

Event ID:

ND1X21 Facility ID: 010613

If continuation sheet Page 3 of 12

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

PRINTED: 11/15/2024 FORM APPROVED OMB NO. 0938-039

	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTIO		(X3) DATE SURVEY COMPLETED 10/29/2024		
	PROVIDER OR SUPPLIE SBURG HEALTHC		7823 (	ADDRESS, CITY, STATE, ZIP COD DLD STATE ROAD 60 ERSBURG, IN 47172	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY 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)	(X5) COMPLETION DATE
				service with maintenance and kitchen staff to inform maintenance of any issues wi exit doors in kitchen or dining room.	
				STEP 4 Collective Actions to monitored to ensure the deficient practice will not recur:  The Maintenance Director/designee will test all doors with an egress 5 days a weeks x 4 weeks, then 3 days week x 4 weeks, then 1 day a week x 4 weeks for no less th months and compliance is maintained to ensure delayed egress is maintained appropriately.  The Administrator/Designee we present the results of these armonthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Finitiated. The QAPI committee determine when 100% complisis achieved or if ongoing monitoring is required.	a s a an 3 vill udits
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System	- Installation			
	failed to maintain t over 6 smoke comp air and gases aroun	on and interview, the facility he ceiling construction in 2 of partments. The ceiling traps hot d the sprinkler and cause the e at a specified temperature.	K 0351	K 351  Preparation or execution of this plan of correction does constitute admission or	11/15/2024 not

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

Event ID:

ND1X21 Facility ID: 010613

If continuation sheet Page 4 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			· ′		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	01	COMPLETED	
		155659	B. W	'ING		10/29/2024	
NAME OF D	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
			7823 OLD STATE ROAD 60				
SELLERS	SBURG HEALTHC	ARE CENTER		SELLER	RSBURG, IN 47172		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		tion, 8.5.4.1.1 states the			agreement of provider of the		
		e sprinkler deflector and the be selected based on the type			truth of the facts alleged or		
	-	type of construction. This			conclusions set forth on the State of		
	-	ould affect 4 residents in two			Deficiencies. The Plan of		
	smoke compartmen				Correction is prepared and		
	smoke comparamen				executed solely because it is		
	Findings include:				required by		
	<i>5</i>				the position of Federal and		
	Based on observation	on and interview with the			State Law.		
		tor (MD) on 10/29/24 during a			The Plan of Correction is		
	tour of the facility b	petween 11:30 a.m. and 1:35			submitted in order to respon	d	
	p.m., in (1) the nurs	es' supply closet 1 of 4			to the allegation of		
	sprinkler heads had	gaps where the sprinkler			noncompliance		
	-	and (2) in the Medical Records			cited during the Life Safety		
	-	ler heads were missing			Annual Survey conducted or	ı	
		g a gap around where the			October 29th, 2024 . Please		
	-	ceiling meet. The MD a greed			accept this plan of correction	n	
	there were gaps aro	und the sprinkler heads.			as the provider's credible		
					allegation of compliance.		
	These findings were	tor and Executive Director			The facility would like to		
	during the exit conf				respectfully request a desk		
	during the exit com	erence.			review. William Jackson HFA		
	3.1-19(b)				William Jackson NFA		
					STEP 1 Corrective action for		
					the residents found to have		
					been affected by the deficier	nt	
					practice:		
					Residents were not harmed by	y the	
					alleged deficient practice.		
					OTED 0 Commonthis and a 11		
					STEP 2 Corrective action tak		
					for those residents having the potential to be affected by the		
					same deficient practice:	l <del>c</del>	
					This deficiency could affect		
					residents in the identified smo	ke	
					compartments. The		
					sprinkler/ceiling gaps identified	d	
					l	ĺ	

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

Event ID:

ND1X21

Facility ID: 010613

If continuation sheet

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

PRINTED: 11/15/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155659		A. BU	A. BUILDING <u>01</u> B. WING			3) DATE SURVEY COMPLETED 10/29/2024	
	PROVIDER OR SUPPLIE			7823 C	ADDRESS, CITY, STATE, ZIP COD OLD STATE ROAD 60 RSBURG, IN 47172		
	SBURG HEALTHC SUMMARY (EACH DEFICIEN			7823 C	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  Were repaired.  STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur: The Maintenance Director/Designee will review a validate quarterly inspections contractors in facility.  STEP 4 Collective Actions to monitored to ensure the deficient practice will not recur: The Maintenance Director/designee will inspect sprinklers 5 days a weeks x 4 weeks, then 3 days a week x 4 weeks, then 1 day a week x 4 weeks for no less than 3 mont and compliance is maintained appropriate ceiling construction around sprinklers.  The Administrator/Designee w present the results of these au monthly to the QAPI committee for no less than 3	and of be all this to in	(X5) COMPLETION DATE
					months. Any patterns that are identified will have an Action F initiated. The QAPI committee determine when 100% complisis achieved or if ongoing monitoring is required.	will	

Event ID: ND1X21 Facility ID: 010613 Page 6 of 12 If continuation sheet

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPLETED
		155659	B. W	B. WING 10/29/2024		
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD	l
NAME OF P	ROVIDER OR SUPPLIER				LD STATE ROAD 60	
SELLEDS	SBURG HEALTHCA	APE CENTER			RSBURG, IN 47172	
SELLENG	BONG HEALTHCA	THE CENTER		SELLEI	ASBORG, IN 47 172	
(X4) ID	SUMMARY S	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 DEFICIENCY)	TE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
K 0521	NFPA 101					
SS=F	HVAC					
Bldg. 01						
	Based on record rev	riew, observation and	K 0	521	K521	11/15/2024
	interview; the facilit	ty failed to ensure egress				
	corridors were not u	sed as a portion of a return air			Preparation or execution of	
	system serving adjo	ining rooms for 57 of 57			this plan of correction does	not
	resident sleeping roo	oms. LSC 9.2.1 requires air			constitute admission or	
	conditioning, heatin	g, ventilating ductwork			agreement of provider of the	
	(HVAC) and related	l equipment to be installed in			truth of the facts alleged or	
	accordance with NF	PA 90A, the Standard for the			conclusions set forth on the	
	Installation of Air C	Conditioning and Ventilating			State of Deficiencies. The Pla	an
	Systems. NFPA 90.	A, Section 4.3.12.1.1 states			of Correction is prepared and	d
	egress corridors in r	nursing and long term care			executed solely because it is	;
	facilities shall not be	e used as a portion of a			required by the position of	
	supply, return, or ex	haust air system serving			Federal and State Law.	
	adjoining areas unle	ess otherwise permitted by			The Plan of Correction is	
	4.3.12.1.3.1 through	4.3.12.1.3.4. This deficient			submitted in order to respon	d
	practice could affect	t all residents, as well as staff			to the allegation of	
	and visitors in the fa	acility.			noncompliance cited during	
					the Annual Life Safety Surve	y
	Findings include:				conducted on October 29th,	
					2024 . Please accept this pla	n
	Based on interview	with the Maintenance Director			of correction as the provider	's
	and Executive Direct	ctor during record review from			credible allegation of	
	9:15 a.m. to 11:30 a	.m. on 10/29/24, the facility			compliance.	
		ied for an annual Life Safety			The facility would like to	
		OOH for using the egress			respectfully request a desk	
	corridor as a return	air system. A waiver for this			review.	
	current year will be	sought following the survey.			William Jackson HFA	
	Based on interview	at the time of record review,				
		rector stated corrections to			STEP 1 Corrective action for	
		o not use the egress corridor			the residents found to have	
	_	n have not been made and a			been affected by the deficien	ıt
		ught. Based on observations			practice:	
		ce Director during a tour of the				
		ent sleeping rooms in the			/p>	
		he egress corridor as a return				
	_	ion to the wall mounted PTAC			STEP 2 Corrective action tak	en
	in each resident slee	eping room, a ceiling mounted			for those residents having th	ie

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COM			COMPLE	ETED
		155659	B. W	ING		10/29/2	2024
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			LD STATE ROAD 60		
SELLERS	SBURG HEALTHC	ARE CENTER			RSBURG, IN 47172		
OLLLLIN	SBUNG FILALITICA	ANE CENTER		JELLEI			
(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	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	* * *	was noted in each room with			potential to be affected by the	e	
		ir located in the central atrium			same deficient practice:		
	_	station and support rooms.					
	Based on interview at the time of the				The deficiency would not affect	ot the	
		laintenance Director agreed all			health or safety of		
		g rooms are using the egress			residents/patients in the facilit	у.	
	corridor for the retu	ırn air system.					
					STEP 3 Measures/systemic		
	_	e reviewed with the			changes put into place to		
		tor and Executive Director			ensure the deficient practice	!	
	during the exit conf	ference.			does not recur:		
					It is the practice of this facili	-	
	3.1-19(b)				that all HVAC systems comp	ly	
					with NFPA 90A at all times.		
					Sellersburg Healthcare Cent		
					would like to request a waive		
					of K521 NFPA 90A life safety	'	
					code standard as this		
					Deficiency would not affect t	he	
					health and safety of the		
					patients/residents here in ou		
					facility based on the following		
					1 We are fully sprinkled fac	lity	
					meeting the Type V (111)		
					minimum. In addition, we have		
					response sprinkler heads insta		
					throughout the facility; we have		
					quarterly inspections by licens		
					sprinkler contractors of the fire	<i>;</i>	
					protection sprinkler system to		
					ensure proper operation.  2 We are fully monitored by	,	
					<ul><li>2 We are fully monitored by Smart Fire Alarm System, with</li></ul>		
					smoke and heat detectors in a		
					hallways tied to fire alarm syst		
					In addition, all resident rooms		
					hardwired with smoke detecto		
					with battery back up tied into t		
					fire alarm system at the nurse		
					station.	·	
	I		1		Januari.		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/15/2024 FORM APPROVED OMB NO. 0938-039

CENTERSTON	MEDICAKE & MEDIC				OMB NO. 0936-039	
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155659	B. WING		10/29/2024	
		100000	D. WING		10/23/2024	
MANGEOGR	DOLUDED OF CURRY TO		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER		7823 C	OLD STATE ROAD 60		
SELL FRS	SBURG HEALTHCA	ARE CENTER		RSBURG, IN 47172		
522221			1			
(X4) ID	SUMMARY S	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 OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
				3 We have HVAC fan shut		
				down circuits that are inspecte	ad	
				1		
				for proper operation by license		
				fire alarm and HVAC contractor	ors.	
				4 Our fire alarm and tie in		
				HVAC circuits are inspected		
				quarterly for proper operation	by	
				licensed fire alarm and HVAC		
				contractors.		
				5 We are inspected by the I	ocal	
				1		
				fire department on their time to		
				at least annually for compliance		
				with all NFPA Fire Regulations	S	
				6 We conduct fire drills as		
				required (1 drill per shift per		
				month, per quarter) and in add	dition	
				we conduct fire drills on all thr		
				shifts monthly at different time		
				-		
				for competency, and to ensure	†	
				compliance with RACE		
				procedures.		
				STEP 4 Collective Actions to	be	
				monitored to ensure the		
				deficient practice will not		
				recur:		
				i ecui.		
				The Maintanarra		
				The Maintenance	,	
				Director/designee will continue		
				ensure all practices in Step 3	are	
				continued.		
				Please see attached letter and	ı l	
				Waiver form.		
				1741701 101111.		
				The Administrator/Designer ::	dl	
				The Administrator/Designee w		
				present the results of these au	ıdıts	

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

Event ID:

ND1X21

Facility ID: 010613

monthly to the QAPI committee for no less than 3 months. Any

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI A. BUILDING 01 COMPLETED B. WING 10/29/2024			ETED	
		155659	B. WI	NG		10/29/	/2024
	PROVIDER OR SUPPLIED			STREET ADDRESS, CITY, STATE, ZIP COD 7823 OLD STATE ROAD 60 SELLERSBURG, IN 47172			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SICY 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
	NFPA 101 Electrical Equipm Extens Based on observatifailed to ensure 2 owere not used as arwiring. NFPA-70/2 specifically permitt cables shall not be fixed wiring. Article chains, because the strip) is now acting wiring of a structuraffect up to 6 staff. Findings include: Based on observatiful Maintenance Directour of the facility p.m., in the Central	ent - Power Cords and on and interview, the facility f 2 power cord daisy chains and as a substitute for fixed 2011, 400.8 state unless and in 400.7 flexible cords and aused for (1) as a substitute for the 400.8 (1) prohibits daisy first extension cord (or power as a substitute for the fixed e. This deficient practice could	K 0	TAG	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.  K920  Preparation or execution of this plan of correction does a 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 respont to the allegation of noncompliance	The e ring	
	another power strip time of observation agreed the two pow together.  This finding was re	b. Based on interview at the at the Maintenance Director verstrips were daisy chained eviewed with the Maintenance ative Director during the exit			cited during the Life Safety Annual Survey conducted or October 29th, 2024. Please accept this plan of correction as the provider's credible allegation of compliance. The facility would like to		

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Event ID:

ND1X21 Facility ID: 010613

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED			EY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155659	A. BUILDING <u>01</u> COMPLETED  B. WING 10/29/2024				
		100000	Б. W.		DDDDGG GUTU GT TT TT TT TT	10/23/2024	
NAME OF P	PROVIDER OR SUPPLIER	8	STREET ADDRESS, CITY, STATE, ZIP COD 7823 OLD STATE ROAD 60				
SELLERS	SBURG HEALTHCA	ARE CENTER			RSBURG, IN 47172		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		IPLETION
TAG	conference.	R LSC IDENTIFYING INFORMATION		TAG	respectfully request a desk		DATE
	conference.				review.		
	3.1-19(b)				William Jackson HFA		
					STEP 1 Corrective action for		
					the residents found to have		
					been affected by the deficier	ıt	
					practice: Residents were not harmed by	, tho	
					alleged deficient practice.	,	
					STEP 2 Corrective action tak	en	
					for those residents having th		
					potential to be affected by th	e	
					same deficient practice:		
					2/2 Daisy chains were remove	:d	
					from facility.		
					STEP 3 Measures/systemic		
					changes put into place to		
					ensure the deficient practice		
					does not recur:		
					All staff were educated that po	ower	
					cord daisy chains cannot be u	sed	
					as a substitute for fixed wiring		
					STEP 4 Collective Actions to	be	
					monitored to ensure the		
					deficient practice will not recur:		
					The Maintenance		
					Director/designee will inspect		
					nurses' station 5 days a week		
					4 weeks, then 3 days a week	x 4	
					weeks, then 1 day a week x 4	.ha	
					weeks for no less than 3 mont and compliance is maintained	<b>I</b>	

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Event ID:

ND1X21 Facility ID: 010613

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

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155659	î ´	JILDING	onstruction 01	(X3) DATE COMPL 10/29/	ETED		
	NAME OF PROVIDER OR SUPPLIER  SELLERSBURG HEALTHCARE CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE				STREET ADDRESS, CITY, STATE, ZIP COD 7823 OLD STATE ROAD 60 SELLERSBURG, IN 47172				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
					ensure "Fire Prevention, Disco & Announcement Policy."  The Administrator/Designee we present the results of these aumonthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Finitiated. The QAPI committee determine when 100% complisis achieved or if ongoing monitoring is required.	ill dits Plan will			

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