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

FORM APPROVED
OMB NO. 0938-0391

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	04/09/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00349752, IN00350182, and IN00351169. Complaint IN00349752 - Substantiated. Federal/State deficiency related to the allegations is cited at F580. Complaint IN00350182 - Substantiated. Federal/State deficiency related to the allegations is cited at F684. Complaint IN00351169 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677 and F686. Survey dates: April 8 and 9, 2021 Facility number: 010613 Provider number: 155659 AIM number: 200221040 Census Bed Type: SNF/NF: 92 Total: 92 Census Payor Type: Medicare: 20 Medicaid: 56 Other: 16 Total: 92 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 20, 2021.	F 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truths of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under the state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed the plan of correction for the complaint survey ending 4/9/2021. Due to the low scope and severity of the survey finding, please find sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facilities allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, please feel free to contact the Executive Director.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	04/09/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.			

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	04/09/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on interview and record review, the facility failed to ensure a resident's (Resident B) family was notified, in a timely manner, of a change in condition for 1 of 3 residents reviewed for notification of changes. Findings include: The clinical record for Resident B was reviewed on 4/8/21 at 1:06 p.m. Diagnosis included, but was not limited to, acute fracture of the 5th metacarpal bone (right index finger). The nurse's note, dated 2/24/21 at 1:22 a.m., indicated the resident complained of pain in the right hand. The resident's right hand and wrist was edematous, red, and shiny. The resident was unable to bend the wrist without pain. The physician was notified and an X-ray of the wrist and hand was ordered. The narrative note, dated 2/24/21 at 3:20 p.m., indicated the X-ray of the right hand returned with an acute fracture of the 5th metacarpal bone.	F 0580	**Corrective action for the residents found to have been affected by the deficient practice:** Resident B was reviewed and the family was notified. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** All residents who have a change in condition have the potential to be affected. A 30 day look back for residents having a change of condition has been completed to ensure the family was notified in a timely manner. Any identified concerns were immediately addressed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator, Director of Nursing/Designee held an	05/09/2021

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	04/09/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	The clinical record indicated the facility did not notify the family of the change in condition until 2/24/21 at 5:00 p.m. During an interview on 4/9/21 at 3:40 p.m., the Director of Nursing indicated the family should have been notified at the time of the change of condition. On 4/9/21 at 3:31 p.m., the Executive Director provided a current copy of the document titled "Notification for Changes in Condition" dated 11/30/2018. It included, but was not limited to, "Policy...It is the policy of this facility to provided resident centered care...The safety of residents...is primary importance...Notifications...When a change in condition is noted, the nursing staff will contact the resident representative...." This Federal tag relates to Complaint IN00349752 3.1-5(a)(2)		in-service with licensed nursing staff to provide education and expectations related to the timely notification of change and the facility “Notification for Changes in Condition” **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Director of Nursing/Unit Manager/Designee will audit residents with a change of condition for timely notification as follows: 5 residents a week x 4 weeks then, 3 residents a week x 4 weeks, then 1 resident a week x 4 weeks or compliance is maintained for no less than 3 months. The Director of Nursing 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 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on interview and record review, the facility failed to ensure a resident (Resident E)	F 0677	**Corrective action for the residents found to have been**	05/09/2021

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	04/09/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	was bathed twice weekly, per the resident's preference, for 1 of 3 residents reviewed for ADL's (Activities of Daily Living). Findings include: The clinical record for Resident E was reviewed on 4/8/21 at 2:51 p.m. Diagnoses included, but were not limited to, diabetes, obesity, respiratory failure, and hypertension. The ADL care plan, dated 3/30/21, indicated the resident required extensive assistance of one staff member with bathing. The resident's preferences evaluation, dated 3/25/21 at 4:00 p.m., indicated the resident preferred a shower. Review of the resident's bathing records, from 3/18/21 to 4/5/21, indicated the resident only received a bed bath on 3/22/21, 3/24/21, and 3/30/21. No showers were documented. The clinical record lacked documentation the resident refused of any showers. During an interview on 4/9/21 at 1:02 p.m., the Director of Nursing indicated residents should be bathed, per their preference, twice weekly. On 4/9/21 at 3:31 p.m., the Executive Director provided a current copy of the document titled "Personal Bathing and Shower" dated 4/25/18. It included, but was not limited to, "Policy...It is the policy of this facility to provide resident centered care...Residents have the right to choose their schedules...including choice for personal hygiene. This includes, but is not limited to, choices about the schedules and type		**affected by the deficient practice:** Resident E's ADL care plan was reviewed to ensure the current shower schedule met the preference of the resident. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** All residents have the potential to be affected by the deficient practice. Shower preferences will be reviewed for all residents and updated as needed to ensure preferences are met. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/Director of Nursing/Designee Nurses have held an in-service for nursing staff for the purposed of education and expectations related to honoring resident bathing preferences and the policy for "Personal Bathing and Shower" **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Director of Nursing/ Unit Manager/Designee will audit 5 residents a week x 4 weeks, then 3 residents a week x 4 weeks, then 1 resident a week x 4 weeks or compliance is maintained for no less than 3 months to ensure residents have their bathing needs	

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	04/09/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	of activities for bathing that may include a shower...The facility will support and accommodate the resident...preferences...." This Federal tag relates to Complaint IN00351169 3.1-38(a)(2)(A)		met per their preference. The Director of Nursing 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 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.			
	Based on interview and record review, the facility failed to ensure residents received insulin injections, in a timely manner, for 2 of 3 residents reviewed for diabetes. (Residents C and D) Findings include: 1. The clinical record for Resident C was reviewed on 4/8/21 at 2:12 p.m. Diagnosis included, but was not limited to, diabetes. The care plan, dated 2/9/21, indicated the resident had diabetes and to administer insulin injections as ordered.	F 0684	**Corrective action for the residents found to have been affected by the deficient practice:** Resident C and D identified as being affected by the deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents receiving insulin administration have the potential to be affected by the deficient practice.	05/09/2021

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	04/09/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	The March 2021 medication administration record (MAR) indicated the following : - From 3/8/21 to 3/21/21, the resident was to receive Basaglar KwikPen (long-acting insulin) 15 units subcutaneously (Subq) in the evening at 8:00 p.m. (due between 7:00 p.m. and 9:00 p.m.) - From 3/22/21 to 3/24/21, the resident was to receive Basaglar KwikPen 22 units subq in the evening at 8:00 p.m. - From 3/25/21 to 3/31/21, the resident was to receive Basaglar KwikPen 12 units subq in the evening at 8:00 p.m. - From 3/9/21 to 3/31/21, the resident was to receive Humulin R (short acting insulin) 25 units at 8:00 a.m. (due between 7:00 a.m. and 9:00 a.m.) - From 3/8/31 to 3/14/21, the resident was to receive Humulin R 20 units at 5:00 p.m. (due between 4:00 p.m. and 6:00 p.m.) - From 3/15/21 to 3/31/21, the resident was to receive Humulin R 25 units at 5:00 p.m. (due between 4:00 p.m. and 6:00 p.m.) - From 3/27/21 to 3/31/21, the resident was to receive Admelog (short acting insulin) 3 units before meals at 7:00 a.m. (due between 6:00 a.m. and 8:00 a.m.), 12:00 p.m. (due between 11:00 a.m. and 1:00 p.m.), and 5:00 p.m. (due between 4:00 p.m. and 6:00 p.m.) The March 2021 MAR indicated the Basaglar Kwikpen insulin due 8:00 p.m. was administered late on the following dates:		An audit of residents receiving insulin administrations has been completed for the last 30 days related to timely administration. Any identified concerns were immediately addressed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/Director of Nursing/UM/Designee held an in-service for all Licensed Nursing staff to provide education and expectations regarding "Medication Administration" **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Director Of Nursing/Unit Manager/Designee will audit for timeliness of insulin administration as follows: 5 residents a week at varying times x 4 weeks, then 3 residents a week at varying times x 4 weeks, then 1 resident a week x 4 weeks or until compliance is maintained for no less than 3 months. The Director of Nursing 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.	

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	04/09/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	- 3/09/21 injection administered 3/10/21 at 12:18 a.m. - 3/15/21 injection administered 3/16/21 at 12:52 a.m. - 3/18/21 injection administered 3/19/21 at 6:41 a.m. - 3/20/21 injection administered 3/21/21 at 2:08 a.m. - 3/22/21 injection administered 3/23/21 at 5:31 a.m. - 3/23/21 injection administered 3/24/21 at 1:10 a.m.. - 3/25/21 injection administered 3/26/21 at 12:37 a.m. - 3/27/21 injection administered 3/27/21 at 12:07 a.m. - 3/28/21 injection administered 3/29/21 at 2:54 a.m. - 3/29/21 injection administered 3/30/21 at 1:24 a.m. - 3/30/21 injection administered 3/31/21 at 6:24 a.m. - 3/31/21 injection administered 4/01/21 at 6:35 a.m. The Humulin R due at 8:00 a.m. was administered late on the following dates: - 3/09/21 injection administered at 12:17 p.m. - 3/10/21 injection administered at 9:29 a.m. - 3/15/21 injection administered at 12:09 p.m. - 3/16/21 injection administered at 10:05 a.m. - 3/17/21 injection administered at 9:17 a.m. - 3/18/21 injection administered at 6:45 p.m. - 3/19/21 injection administered at 3:42 p.m. - 3/20/21 injection administered at 10:07 a.m. - 3/21/21 injection administered at 2:40 p.m. - 3/22/21 injection administered at 4:04 p.m. - 3/24/21 injection administered at 12:21 p.m.. - 3/26/21 injection administered at 10:22 a.m. - 3/27/21 injection administered at 9:29 a.m.			

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	04/09/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	- 3/28/21 injection administered at 10:10 a.m. - 3/29/21 injection administered at 10:37 a.m. - 3/30/21 injection administered at 10:50 a.m. The Humulin R due at 5:00 p.m. was administered late on the following dates: - 3/11/21 injection administered at 6:44 p.m. - 3/17/21 injection administered at 6:11 p.m. - 3/18/21 injection administered at 6:47 p.m. The Admelog due at 7:00 a.m. was administered late on the following dates: - 3/27/21 injection administered at 9:29 a.m. - 3/28/21 injection administered at 10:09 a.m. - 3/29/21 injection administered at 10:36 a.m. - 3/30/21 injection administered at 10:50 a.m. - 3/31/21 injection administered at 8:24 a.m. The April 2021 MAR indicated the resident was to receive the following: - From 4/1/21 to 4/6/21, the resident was to receive the Basaglar Kwikpen 22 units subq at 8:00 p.m. - From 4/1/21 to 4/7/21, the resident was to receive the Humulin R 25 units subq at 8:00 a.m. and 5:00 p.m. - From 4/1/21 to 4/7/21, the resident was to receive Admelog 3 units subq at 7:00 a.m., 12:00 p.m., and 5:00 p.m. The April 2021 MAR indicated the Basaglar Kwikpen insulin was administered late on 4/6/21 at 11:21 p.m. The Humulin R 8:00 a.m. dose was administered late on the following dates: - 4/1/21 injection administered at 11:33 a.m.			

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	04/09/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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

- 4/3/21 injection administered at 2:17 p.m.
- 4/4/21 injection administered at 12:27 p.m.
- 4/5/21 injection administered at 2:03 p.m.
- 4/6/21 injection administered at 9:20 a.m.
- 4/7/21 injection administered at 2:05 p.m.

The Admelog 7:00 a.m. dose was administered late on the following dates:
- 4/1/21 injection administered at 11:33 a.m.
- 4/3/21 injection administered at 2:16 p.m.
- 4/4/21 injection administered at 12:25 p.m.
- 4/5/21 injection administered at 2:03 p.m.
- 4/6/21 injection administered at at 9:19 a.m.
- 4/7/21 injection administered at 2:06 p.m.

The Admelog 12:00 p.m. dose was administered late on the following dates:
- 4/3/21 injection administered at 2:17 p.m.
- 4/5/21 injection administered at 2:04 p.m.
- 4/6/21 injection administered at 1:09 p.m.
- 4/7/21 injection administered at 2:05 p.m.

The Admelog 5:00 p.m. dose was administered late on the following dates:
- 4/5/21 injection administered at 7:12 p.m.
- 4/6/21 injection administered at 6:18 p.m.

During an interview on 4/9/21 at 11:40 a.m., LPN (Licensed Practical Nurse) 3 indicated medications can be given an hour before and up to a hour after the scheduled time they were due.

2. The clinical record for Resident D was reviewed on 4/8/21 at 4:20 p.m. Diagnosis included, but was not limited to, diabetes.

The care plan, dated 10/6/20, indicated the resident was a diabetic and to administer diabetes medication as ordered.

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	04/09/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	The March 2021 MAR indicated the resident was to receive Basaglar KwikPen 10 SQ units in the evening at 8:00 p.m. (due between 7:00 p.m. and 9:00 p.m.) The March 2021 MAR indicated the insulin was given late on the following dates: - 3/1/21 injection administered 3/2/21 at 12:45 a.m. - 3/4/21 injection administered 3/5/21 at 7:36 a.m. - 3/6/21 injection administered 3/7/21 at 2:05 a.m. - 3/8/21 injection administered 3/9/21 1:58 a.m. - 3/9/21 injection administered 3/10/21 at 3:42 a.m. - 3/13/21 injection administered 3/14/21 at 12:15 a.m. - 3/14/21 injection administered 3/15/21 at 1:38 a.m. - 3/18/21 injection administered 3/19/21 at 6:50 a.m. - 3/20/21 injection administered 3/21/21 at 2:10 a.m. - 3/22/21 injection administered 3/23/21 at 5:41 a.m. - 3/23/21 injection administered 3/24/21 at 1:22 a.m. - 3/25/21 injection administered 3/26/21 at 12:51 a.m. - 3/29/21 injection administered 3/30/21 at 1:27 a.m.. - 3/30/21 injection administered 3/31/21 at 6:29 a.m. - 3/31/21 injection administered 4/1/21 at 6:42 a.m. The April 2021 medication administration record indicated the resident was to receive Basaglar KwikPen 10 units Subq in the evening at 8:00			

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	04/09/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	p.m. (due between 7:00 p.m. and 9:00 p.m.) The April 2021 MAR indicated the insulin was given late on the following dates: - 4/3/21 injection administered 4/4/21 at 3:28 a.m. - 4/6/21 injection administered 4/7/21 at 7:50 a.m. - 4/7/21 injection administered 4/8/21 at 2:49 a.m. On 4/8/21 at 4:30 p.m., the Executive Director provided a current copy of the document titled "Medication Administration" dated 12/14/17. It included, but was not limited to, "MAR: Medication Administration Record - the legal documentation for medication administration...Medications will be charted when given...Medications will be administered within the time frame of one hour before up to one hour after time ordered...." This Federal tag relates to Complaint IN00350182 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and			

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	04/09/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on interview and record review, the facility failed to ensure wound treatments were in place for a resident (Resident E), upon facility admission, for 1 of 3 residents reviewed for pressure ulcers. Findings include: The clinical record for Resident E was reviewed 4/8/21 at 2:51 p.m. Diagnoses included, but were not limited to, unstageable (full thickness tissue loss in which the base of the ulcer is covered with slough) pressure ulcers to the sacrum and right buttock. The care plan, dated 3/22/21, indicated the resident had impaired skin integrity and to complete treatments as ordered. The admission skin grid pressure sheet, dated 3/18/21, indicated the resident had an unstageable area to the sacrum which measured 5.5 cm (centimeters) in length, 4 cm in width with a depth of 0.1 cm. The current treatment consisted of santyl (wound debridement), calcium alginate, and a foam dressing. The admission skin grid pressure sheet, dated 3/19/21, indicated on 3/18/21, the resident had an unstageable area to the right buttock which measured 1 cm in length, 1 cm in width with a depth of 0.1 cm. The current treatment consisted of santyl, calcium alginate, and a foam dressing. Review of the March 2021 treatment	F 0686	**Corrective action for the residents found to have been affected by the deficient practice:** Resident E was not harmed. Resident E no longer resides at the facility. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** All newly admitted residents who have a pressure area have the potential to be affected by the deficient practice. An audit of residents admitted with a pressure wound over the last 30 days has been completed to ensure a treatment was in place at time of admission. Any identified concerns were immediately addressed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/Director of Nursing/Designees have in-service licensed Nursing staff on the “Skin Care and Wound Management Overview Policy and Procedure” as it relates to ensuring wound treatments are in place for pressure ulcers upon admission to the facility.	05/09/2021

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	04/09/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	administration record indicated there were no treatments completed to the wounds between 3/18/21 and 3/22/21. During an interview on 4/9/21 at 3:34 p.m., the Director of Nursing indicated he could not find any documented treatments between 3/8/21 and 3/22/21. On 4/9/21 at 3:31 p.m., the Executive Director provided a current copy of the document titled "Monitoring A Wound" dated 7/1/16. It included, but was not limited to, "Policy...Each resident/patient is evaluated upon admission...Procedure...Implement wound treatments as ordered. This Federal tag relates to Complaint IN00351169 3.1-40(a)(2)		**Corrective actions to be monitored to ensure the deficient practice will not recur:** The Director of Nursing/Unit Manager/ Designee will audit residents admitted with pressure ulcers to ensure wound treatment orders are in place at time of admission to the facility. The audit will occur as follows: 5 newly admitted residents per week x 4 weeks, then 3 newly admitted residents per week x 4 weeks, then 1 newly admitted resident per week x 4 weeks or until compliance is maintained for no less than 3 months. The Director of Nursing 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.	