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	11/21/2023

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00419997. Complaint IN00419997 - Federal/State deficiencies related to the allegations are cited at F684 and F770. Survey dates: November 20 and 21, 2023 Facility number: 010613 Provider number: 155659 AIM number: 200221040 Census Bed Type: SNF/NF: 96 Total: 96 Census Payor Type: Medicare: 9 Medicaid: 72 Other: 15 Total: 96 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 22, 2023.	F 0000	Sellersburg respectfully ask for consideration for a desk review for compliant survey IN00419997.	
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			

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

Shamika Palmer | RN RDCO | 12/01/2023

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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	professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to ensure the treatment for a resident's venous wound was completed, as ordered by the physician, for 1 of 3 residents reviewed for wound care. (Resident B) Findings include: The clinical record for Resident B was reviewed on 11/20/23 at 10:49 a.m. The diagnosis included, but was not limited to, vascular wounds to the bilateral lower extremities. On 11/20/23 at 12:00 p.m., Resident B was observed sitting up in his wheelchair in his room with an unna boot (special bandage used for the treatment of venous wounds/ulcers) in place to his bilateral lower extremities. The care plan, dated 12/20/21, indicated the resident had impaired skin integrity and to complete treatments as ordered by the medical provider. The November 2023 Treatment Administration Record (TAR) indicated staff were to cleanse the resident's wounds to the right lower extremity with normal saline or wound cleanser, pat dry, apply hydrofera blue to the open areas and cover with an unna boot every day shift on Tuesday and Friday. The November 2023 TAR lacked documentation of the completion of the treatment on 11/10/23. During an interview on 11/21/23 at 12:05 p.m., RN (Registered Nurse) 4 indicated once a treatment	F 0684	**Corrective action for the residents found to have been affected by the deficient practice:** Resident B could not be identified as resident B was part of a complaint survey. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents with wound care treatments have the potential to be affected by this alleged deficient practice. DON /Designee completed a 14-day look back of treatment administration records to ensure all treatments were completed as ordered per MD. DON/Designee completed a full house audit per observation to ensure all treatments were dated as current and completed per MD order. Any treatments found to have not been completed we immediately completed and MD and RP notifications were made. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** DON/Designee educated licensed nurses regarding facilities policy	12/11/2023

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	was completed, it should be signed off on the TAR. On 11/21/23 at 12:40 p.m., the Director of Nursing provided a current, undated copy of the document titled " Skin Care and Wound Management". It included, but was not limited to, "Policy...Residents/patients admitted with...skin integrity issues will receive treatment as indicated...." This Citation relates to Complaint IN00419997 3.1-37		"Skin Care and Wound Management" with emphasis on completing treatments in timely manner as ordered per MD. **Corrective actions to be monitored to ensure the deficient practice will not recur:** DON/Designee will review through clinical meeting, TARS to ensure all treatment orders signed off as completed at 100%, 5 x's weekly x's 12 weeks. DON/Designee will random select 5 resident 5 x's weekly x's 12 weeks to ensure treatment complete as ordered per MD. The DON/Unit Manager/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. Date of alleged compliance 12/11/2023	
F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.			

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	(i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. Based on interview and record review, the facility failed to ensure laboratory services were obtained, as ordered by the physician, for 1 of 3 residents reviewed for laboratory services. (Resident B) Findings include: The clinical record for Resident B was reviewed on 11/20/23 at 10:49 a.m. The diagnoses included, but were not limited to, chronic osteomylitis, diabetes and end stage renal disease. The physician's order, dated 10/25/23, indicated to obtain Resident B's weekly creatine level, in the evening, for six weeks. The creatine level was to be drawn once a week on Fridays for six weeks. Review of the November 2023 Treatment Administration Record indicated the resident's creatine level was not obtained on Friday, 11/10/23, as ordered by the physician. During an interview on 11/21/23, the Director of Nursing indicated the lab was not obtained on 11/10/23. On 11/21/23 at 12:40 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...The facility is responsible for the quality and timeliness of services...The facility will request laboratory...services...when ordered by a physician...."	F 0770	**Corrective action for the residents found to have been affected by the deficient practice:** Resident B could not be identified as resident B was part of a complaint survey. **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 have the potential to be affected by this alleged deficient practice. DON /Designee completed a 30-day look back audit to ensure all labs orders were completed fully per MD order. Any found to not have been completed, had notification to MD and any new orders implemented per MD as indicated. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** DON/Designee educated licensed nurses regarding facilities policy “Laboratory and Radiological Services and Results Reporting” with emphasis on completing all labs per MD order.	12/11/2023

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	This Citation relates to Complaint IN00419997 3.1-49(a)		**Corrective actions to be monitored to ensure the deficient practice will not recur:** DON/Designee will review through clinical meeting any new labs orders to ensure completed as ordered per MD 5x's weekly x's 12 weeks. The DON/Unit Manager/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. Date of Alleged Compliance 12/11/23	