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	07/29/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 IN00412690, IN00412790 and IN00413727. This visit resulted in a Partially Extended Survey - Substandard Quality of Care - Immediate Jeopardy. Complaint IN00412690 - Federal/State deficiency related to the allegation is cited at F600. Complaint IN00412790 - No deficiencies related to the allegations are cited. Complaint IN00413727 - Federal/State deficiency related to the allegation is cited at F600. Survey dates: July 25, 26, 27, 28, and 29, 2023 Facility number: 010613 Provider number: 155659 AIM number: 200221040 Census Bed Type: SNF/NF: 102 Total: 102 Census Payor Type: Medicare: 7 Medicaid: 81 Other: 14 Total: 102 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 31, 2023.	F 0000	**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.** **The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the complaint survey conducted on July 25-28, 2023.** **Please accept this plan of correction as the provider's credible allegation of compliance.** **The facility would like to respectfully request a desk review.** **Monica Dirbas, LNHA** -	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Monica Dirbas	Executive Director	08/06/2023

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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F 0600 SS=J Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observation, interview and record review, the facility failed to ensure a resident (Resident B) was free from staff to resident abuse for 1 of 3 residents reviewed for abuse. This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 7/8/23 when Resident B alleged the Social Services Director (SSD) kissed him. The SSD was banned from the resident's room on 7/8/23. Resident B had new negative behaviors of acting out, thrashing, and hitting his head on his bed mattress on 7/11/23. The SSD had sent the resident explicit photos of herself to an IPAD the resident had in his possession on 7/14/23 and 7/17/23. On 7/18/23, the resident had an increase in behaviors of cursing and yelling at staff with unsuccessful redirection. The Executive Director, Director of Nursing and Regional Director of Clinical Operations were notified of the Immediate Jeopardy on 7/27/23. The Immediate Jeopardy was	F 0600	**Corrective action for the residents found to have been affected by the alleged deficient practice:** Resident B was assessed related to the alleged deficient practice with no injury noted. Resident B is to be assessed and evaluated per facilities Nurse Practitioner and Psych NP for any physical or psychosocial concerns. Orders and care plans to be updated as indicated. Staff member in question is no longer employed by facility. **Corrective action taken for those residents having the potential to be affected by the same alleged deficient practice:** DON/Designee has completed a	07/30/2023

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	removed on 7/28/23, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Findings include: The clinical record for Resident B was reviewed on 7/25/23 at 12:39 p.m. The resident's diagnoses included, but were not limited to, traumatic subdural hemorrhage with loss of consciousness, ventilator dependent, acute and chronic respiratory failure with hypoxia, and fractures of the skull base, right sided zygomatic, right side lateral orbital wall, left tibia, right forearm and cervical. The quarterly MDS (Minimum Data Set) assessment, dated 7/13/23, indicated the resident's cognition was intact. The follow up incident report, dated 7/10/23, indicated during an investigation of an abuse allegation, Resident B alleged a new concern to Staff Member 7 that the SSD would come to his room and kiss him. The progress note, dated 7/11/23 at 2:13 p.m., indicated the resident had continued to display previously observed behaviors such as aggressiveness, yelling, and using profanity towards staff at numerous times throughout the day. (There were no other behavior notes prior to 7/11/23.) The care plan, dated 7/12/23, indicated Resident B had a behavior problem of acting out, thrashing and hitting his head on the mattress when he does not get what he wants; expects staff to spend extended amounts of time with him after care had been provided; attempts to manipulate staff to stay in his room longer; and had made allegations		full house audit of all residents able to be interviewed for any concerns of abuse. Those unable to be interviewed had skin assessments complete per licensed staff and were assessed for any signs and symptoms of decline in psychosocial well-being. DON/Designee have reviewed and audited all facility communication devices for any inappropriate communication between staff and residents. DON/Designee will review current residents documentation on-going through daily clinical meeting for any decline in psychosocial well-being and increased behavior's and report any concerns to NP and Psych as appropriate and carry out any orders related to concerns and update plan of care as indicated. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** DON/Designee educated all staff on facilities policy " Indiana's Abuse Neglect and Misappropriation of Property." With focus on the types of abuse, inappropriate communication, via in person or electronic communication devices and proper boundaries between staff and residents. All staff educated on	

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	of sexual inappropriateness by staff yet denied the allegations. The interventions included, but were not limited to, approach/speak in a calm manner, consult behavioral health as needed, communicate with resident regarding behaviors, encourage family/girlfriend to visit more often and spend more time with resident to decrease behaviors, intervene as necessary to protect the rights and safety of others, minimize potential for disruptive behaviors by offering tasks that divert attention, encourage to express feelings, and notify physician of increased episodes of behaviors. The progress note, dated 7/18/23 at 7:48 a.m., indicated the resident had increased behaviors, cussed and yelled at the clinical staff. Re-direction of the resident was attempted but was unsuccessful. During an interview of 7/25/23 at 1:55 p.m., Resident B indicated no one had ever abused or mistreated him in any way. He denied any kind of relationship with the SSD. They were rumors and he was not sure why the rumors started. The SSD was better than all the other aides. The resident denied any texting, touching, or intimacy of any kind. The SSD was banned (on 7/8/23) from his room. He was sick of the aides as he had to wait on them. The rumors had upset him. He just felt like people were not listening to him. During a confidential interview on 7/25/23 at 3:58 p.m., the complainant indicated that the SSD and Resident B were having a relationship. It was reported to the complainant that a staff member witnessed Resident B and the SSD kiss. The SSD was in the resident's room a lot, and there was a lot of texting between the two. The SSD texted the resident's ex-girlfriend and the family called and		Resident rights, standard of conduct and cell phone policy DON/Designee will educate all licensed nurses and IDT on the facility's policy for Change in Condition, with focus on behavior notification and follow up with the appropriate psychosocial evaluation and monitoring **Corrective actions to be monitored to ensure the deficient practice will not recur:** Executive Director/Designee will ask a series of questions to three residents and three staff members three times a week for any experienced/witnessed suspected abuse, neglect or misappropriation for four weeks then twice a week for four weeks then monthly times three months. DON/Designee will review current resident's documentation on-going through daily clinical meeting for any decline in psychosocial well-being and increased behaviors, ~~a~~nd report any concerns to NP and Psych as appropriate and carry out any orders related to concerns and update plan of care as indicated DON/Designee will monitor staff to resident interactions through observation during resident to staff interaction throughout facility on	

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	had the SSD banned from his room. The resident received texts from the SSD that stated, "I love you" and Resident B responded with "you make my d*** hard". During an interview on 7/25/23 at 4:10 p.m., Staff Member 7 indicated she had witnessed the text messages between Resident B and the SSD. The resident would ask Staff Member 7 to send texts for him because of the limited use of his hands. She recognized the number as a number she had in her phone, which was the number of the SSD. The resident saved the SSD's number under a different name to hide the communication. Before she realized she had been sending texts to the SSD for the resident, she was told by the resident that it was his wife. The resident texted on the IPAD and the texts are very big and several texts could be seen. There were texts that said "I love you" back and forth. There was a text with the word masturbating in it. She also saw a text to the resident from the SSD number that said when the SSD was "rubbing lotion on his arms and legs, she did not know how she had the self-control to stop". The two were still texting. The resident made it clear to her that they were still in communication. The SSD used to never come down and help feed the residents on the 400 Hall. After Resident B admitted, the SSD would feed the resident at just about every single meal with the door closed. On this hall, the doors are not allowed to be closed due to the tracheotomies. Staff Member 7 had entered the resident's room one day when the door was closed to check on him. The SSD was in there feeding the resident and gave her a hateful look. The staff member did not understand why the SSD would look at her that way. During an interview on 7/25/23 at 4:22 p.m., Staff		an ongoing basis randomly selecting staff members from all departments 5x's daily for 4 weeks, then 5x's weekly for 4 weeks, then 2x's weekly for 4 weeks, then 1x's weekly on a continuing basis to ensure professional boundaries are upheld and no concerns with abuse are noted. 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 Compliance: 7/28/23- compliance date was approved on this date due to IJ status	

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	Member 8 indicated she did observe a number on Resident B's phone and recognized the number as the SSD, because all the staff had that number. She had not ever texted for the resident. During an interview on 7/25/23 at 4:25 p.m., Staff Member 10 indicated she could not say for sure whether there was a relationship between the SSD and Resident B. Resident B had told Staff Member 10 that he and the SSD were still in communication when there was not supposed to be any communication between them. During an interview on 7/25/23 at 4:29 p.m., Staff Member 11 indicated she had spoken with the SSD and asked why she was at the facility late every night. The SSD told her that she was told she had to. She had not seen any texts between Resident B or the SSD. Staff Member 11 told the SSD that if she was doing what she heard, she needed to stop. The staff had an obligation to the residents and that line cannot be crossed. During an interview on 7/26/23 at 11:28 a.m., Staff Member 12 indicated she reported the texting on 7/6/23. Prior to Resident B admitting to the facility the SSD was never on the hall. After Resident B came to the facility the SSD was on the hall and fed the resident breakfast, lunch and dinner. The resident would have Staff Member 12 and Staff Member 15 text for him. He asked Staff Member 15 to text someone for him. When both staff members asked the resident who the someone was, the resident just laughed. Resident B told both staff members that the SSD was not allowed in his room anymore. Staff Member 12 exited the room at that time and asked the DON (Director of Nursing) about the SSD not being allowed in the resident's room and about the texts. The DON asked her to look at the number next time. She did and she and			

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	the Unit Manager confirmed the number belonged to the SSD and reported it. Resident B asked Staff Member 12 and Staff Member 15 who they thought the person was the resident was having them text. Staff Member 12 responded with the SSD's name and Resident B stated "yes". Resident B had Staff Member 12 send a text to the number that said, "stick with the plan" and "are you coming down for lunch". Staff Member 12 could see previous texts due to the size of the IPAD screen. One text said, "I love you" and another "good night", all from the number of the SSD. There was a message that Resident B had sent to the SSD number which said, "you make my d*** so hard". This past Friday (7/21/23), there was a text sent from Resident B to the SSD number that said, "you take such good care of daddy" and then the response from the SSD number was "I love you so much". Not long after that, food was delivered to the resident. Staff Member 12 was not sure if it was a coincidence or not but thought it strange that food was delivered to the resident not long after the text messages. During a telephone interview on 7/26/23 at 1:02 p.m., Staff Member 14 indicated the SSD had purchased clothes for Resident B. A delivery came with the SSD name on the box. Staff Member 14 asked who the clothes were for and was told Resident B. She was not sure whether the SSD had purchased the IPAD for Resident B. During an interview on 7/26/23 at 1:31 p.m., Staff Member 15 indicated that Resident B had called both she and Staff Member 12 to his room. Resident B told them both that he and the SSD had been texting and he had the SSD number saved as another woman. The only name Staff Member 15 had seen was the other woman with a heart emoji next to the name.			

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	During an interview on 7/27/23 at 9:45 a.m., the ED (Executive Director) indicated she had the SSD come in for an interview. The SSD let her look at her phone. There were no inappropriate messages that she could see. The SSD told her the IPAD was hers and she had purchased it during COVID for facetime visits with families. The SSD was letting Resident B use the IPAD until he got his cell phone and was better able to work the phone since he only had the use of one hand. Since the IPAD did not belong to the resident, they were going to ask to see the IPAD and give him the chance to delete his personal information in order not to violate his rights. The progress note, dated 7/27/23 at 10:14 a.m., indicated the DON and ED discussed with resident that the IPAD was loaned to him for short term use and that facility needed to retrieve the IPAD related to the ongoing investigation. The resident got upset and stated, "No you cannot have it, I have personal stuff in there I do not want anyone to see". It was explained to the resident that he would have adequate time to remove anything personal that he did not want anyone to see. The resident agreed to 1 hour of time to remove his personal information. During an observation of the IPAD on 7/27/23 at 1:35 p.m., with the DON present, the IPAD showed no text messages between the resident and the SSD. Review of the history on the IPAD, under photos, there were 5 explicit photos sent to the resident on 7/14/23 and 7/17/23. The DON identified the person in the photos as the facilities SSD. One of the photos sent to the IPAD by the SSD while the resident had the IPAD in his possession was of the SSD without clothing.			

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	On 7/25/23 at 12:15 p.m., the Director of Nursing provided a current, undated copy of the document titled "INDIANA Abuse & Neglect & Misappropriation of Properly". It included, but was not limited to, "Mistreatment...In Indiana is defined as staff...exploiting a resident...Examples...romantic and/or inappropriate relationship between staff and resident that does not involve physical intimacy...texting romantic notes to a resident...Policy...It is the policy of this facility to provide resident centered care that meets the psychosocial...and emotional needs...of the residents...It is the intent of this facility to prevent abuse, mistreatment...of residents...." The Immediate Jeopardy, that began on 7/8/23, was removed on 7/28/23, when the facility conducted the following: The DON/Designee completed a full house audit of all interviewable residents for any concerns of abuse (dated 7/27/23); skin assessments were completed on all residents unable to complete interviews and assessed for signs and symptoms of decline in psychosocial well-being (dated 7/27/23); all facility communication devices were reviewed and audited for any inappropriate communication between staff and residents (dated 7/27/23); all staff were educated on abuse with focus on types of abuse, inappropriate communications via in person or electronic communication devices, proper boundaries between staff and resident (dated 7/27/23); resident rights (dated 7/28/23); standard of conduct and cell phone policy (dated 7/27/23); change of condition with focus on behavior notification and follow up with the appropriate psychosocial evaluation and monitoring (dated 7/27/23). This Federal tag relates to Complaints IN00412690 and IN00413727.			

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