STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155659	A. BUILDING _____ B. WING _____	**06/23/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure the timely administration of medications for 3 of 5 residents reviewed for Quality of Care. (Residents C, D, and B) Findings include: 1. An interview with Resident C, on 6/23/20 at 11:03 a.m., she indicated she had to wait up to 2 hours for her call light to be answered. She had to press her call light for her medications often. Her blood sugars were supposed to be checked and she was suppose to receive her insulin before meals every day. Her blood sugars were often checked and the insulin was administered well after she had finished eating. Today her blood sugar was 347 because they gave her insulin too late. During a continuous observation and interview, on 6/23/20 from 11:25 a.m. to 1:00 p.m., Resident C received her lunch tray at 11:58 a.m. The resident had not received any insulin prior to receiving her lunch tray. The resident indicated she had not received any insulin prior or during receiving her lunch tray. During an interview at 12:40 p.m., RN 4 indicated he did not believe the resident had orders for an accucheck or insulin. After looking at the residents MAR (Medication Administration Record), he indicated the MAR indicated [REDACTED]. He did not realize the resident had an order for [REDACTED]. Resident C did not have any admelog in the medication cart. RN 4 texted the NP (Nurse Practitioner) for an order to substitute 14 units of Humalog. At 12:55 p.m. the RN administered 14 units of Humalog to the resident. The resident had completed eating her lunch tray prior to the administration. The clinical record for Resident C was reviewed on 6/23/20 at 2:10 p.m. The resident's [DIAGNOSES REDACTED]. The Admission MDS (Minimum Data Set) Assessment, dated 6/2/20, indicated the resident was cognitively intact. The care plan, dated 6/4/20, indicated the resident had DMII. Interventions included, but were not limited to, administer medications as ordered by the doctor. The physician's orders [REDACTED]. The resident's Admelog 100 Unit/mL solution was documented as being administered more than 1 hour past the administration times of 12:00 p.m. on June 23, 2020. 2. During a continuous observation, on 6/23/20 from 11:25 a.m. to 1:00 p.m., Resident D received his lunch tray between 11:30 and 11:40 a.m. He had not received his insulin or have his blood sugar checked until 12:15 p.m., after he had already been served his lunch tray. The clinical record for Resident D was reviewed on 6/23/20 at 2:15 p.m. The resident's [DIAGNOSES REDACTED]. The care plan, dated 5/6/20, indicated the resident had DMII. Interventions included, but was not limited to, administer medications as ordered by the doctor. The physician's orders [REDACTED]. The resident's [MEDICATION NAME] FlexTouch 100 unit/mL Solution was documented as being administered more than 1 hour past the administration time of 8:00 a.m. on June 23, 2020. The resident's HumaLog 100 unit/mL Solution was documented as being administered more than 1 hour past the administration times of 5:00 a.m. and 11:00 a.m. on June 23, 2020. During an interview on 6/23/20 at 12:40 p.m., RN 4 indicated when he had gone to administer Resident D's insulin, he had already received his tray. 3. During an interview on 6/23/20 at 11:05 a.m., Resident B indicated her medications were always late. She was supposed to have an acid reflux medication first thing in the morning on an empty stomach. She often received the medication well after breakfast. By the time she received her medication, the acid had already started to kick in and was very uncomfortable for her. The clinical record for Resident B was reviewed on 6/23/20 at 2:20 p.m. The resident's [DIAGNOSES REDACTED]. The Admission MDS assessment, dated 6/10/20, indicated the resident was cognitively intact. The care plan, dated 6/8/20, indicated the resident had GERD. Interventions included, but was not limited to, administer medications as ordered. The physician's orders [REDACTED]. The resident's [MEDICATION NAME] 40 mg was documented as being administered more than 1 hour past the administration time of 8:00 a.m., on June 23, 2020. During an interview on 6/23/20 at 9:30 a.m., RN 4 indicated he had been working the floor often over the last 2 to 3 months. Several employees had quit because they were scared of COVID-19. AT 12:40 p.m., he indicated he was usually on top of getting his medications passed. During an interview on 6/23/20 at 9:53 a.m., LPN (Licensed Practical Nurse) 5 indicated It was very rough to get all of their work done. During an interview on 6/23/20 at 2:20 p.m., the Regional Director of Clinical Operations (RDCO) indicated if a medication order specified With meals they should be given within the vicinity of the meal time. With the insulin, it would not be acceptable for the resident to get their tray and receive it an hour later. If scheduled before the meal expect it to be given before the meal. Medications can be given an hour before and an hour after. Anything after one hour after the administration time would be considered a late administration. The most current Staffing in a Crisis Situation Policy and Procedure, Dated 3/25/20, provided on 6/23/20 at 2:15 p.m., by the DON, included, but was not limited to, . 1. During an emergency type situation, the management team will monitor staffing availability on a daily basis to assure adequate numbers of staff members are present to assist with patient care . The most current Medication Administration Policy and Procedure, dated 8/3/10, last revised, 12/14/17, provided on 6/23/20 at 2:15 p.m., included, but was not limited to, . f. Observe the five rights in giving each medication . ii. the right time . ff. Medications will be administered within the time frame of one hour before up to one hour after time ordered . For medication to be taken around meals: 1. Before Meals: Provide medications thirty (30) minutes before meal time . This Federal tag relates to Complaint IN 908 3.1-37(a)

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.