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 _____	07/23/2020

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 0604 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident was free from physical restraints after the resident attempted to return to his room from the lobby on his own. This deficient practice affected 1 of 1 resident reviewed for restraints. (Resident B) Findings include: The clinical record for Resident B was reviewed on 7/21/20 at 11:05 a.m. The resident's [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) assessment, dated 7/12/20, indicated the resident was alert and oriented and able to answer questions. The resident required supervision when wheeling his wheelchair. During an interview, on 7/22/20 at 9:45 a.m., the resident indicated he had a problem with the front desk receptionist about a week ago on a Thursday. He had just come back from [MEDICAL TREATMENT] and was put in the front lobby to wait on someone to take him back to his room. He asked for assistance to go back to his room, because he had to go to the bathroom and he was tired from [MEDICAL TREATMENT]. The receptionist told him he would take him back to his room, but he was too busy at that time. The resident replied he would start wheeling himself. The receptionist asked him why he would not just sit and look out the window while he waited? The resident responded he really wanted to go back to his room. The receptionist came over and moved him into a corner by the sliding door, locked his brakes and put another wheelchair behind him and said Now lets see you move. The resident sat there about 20 minutes trying to get out of the area by the sliding door, before someone came and took him to his room. During an interview, on 7/22/20 at 10:20 a.m., the front desk receptionist indicated he could not recall any problems with a resident trying to wheel himself back to his room instead of waiting on help. During an interview, on 7/22/20 at 10:50 a.m., the Administrator indicated the resident spoke to her the next day on 7/17/20 (Friday), about the front desk receptionist locking his wheelchair. She had not looked into the resident's complaint at this time. On 7/23/20 at 10:15 a.m., the Director of Nursing presented a copy of the facility's current policy titled Physical Restraint and Management with a revision date of 6/15/18. Review of this policy at this time included, but was not limited to, Definitions: .Physical restraint: for the purpose of this policy is defined as any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria: is attached or adjacent to the resident's body; Cannot be removed easily by the resident; Restricts the resident's freedom of movement .Physical restraints may include but are not limited to: .wheelchair bars/brakes, .placing chairs .close to the wall that prevents a resident from rising or exiting voluntarily .Policy: .Residents have the right to be free from any physical or chemical restraints imposed for the purpose of discipline or convenience, and not required to treat the resident's medical symptoms, . 3.1-3(w)
F 0676 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received showers twice weekly and failed to ensure a resident was assisted with meal intake for 2 of 4 residents reviewed for activities of daily living. (Resident F, and Resident G) Findings include: 1. The clinical record for Resident F was reviewed on 7/21/20 at 11:27 a.m. [DIAGNOSES REDACTED]. The 5 day medicare MDS (Minimum Data Set) assessment indicated the resident's cognition was intact. During an interview and observation, on 7/22/20 at 10:20 a.m., the resident was resting in bed. She indicated she was supposed to get a shower every Tuesday and Thursday but had not been getting them as scheduled. Review of the the April 2020 resident care report indicated the resident received two showers and three bed baths between 4/1/20 and 4/30/20. Review of the May 2020 resident care report indicated the resident received four showers and two bed baths between 5/1/20 and 5/31/20. During an interview on 7/22/20 at 11:00 a.m., Staff Member 8 indicated when they are short staffed, there was just not enough time to give the resident's showers. During an interview on 7/23/20 at 10:09 a.m., Staff Member 9 indicated there were times when she could not get to her showers due to the high acuity and amount of staff in the building. On 7/23/20 at 10:15 a.m., the Director of Nursing provided a current copy of the document titled Routine Resident Care, dated 4/6/16. Routine Resident Care: care that in not necessarily medically or clinically based but necessary for quality of life .It is the policy of this facility to promote resident centered care .Routine care by a nursing assistant includes, but is not limited to .Assisting .bathing 2. a. The clinical record for Resident G was reviewed on 7/23/20 at 6:08 a.m. [DIAGNOSES REDACTED]. The annual MDS (Minimum Data Set) assessment dated [DATE] indicated the resident's cognition was intact. On 7/22/20 at 10:55 a.m., Resident G was observed sitting up in her wheel chair. The resident had bilateral amputations of both hands. Resident G indicated she had only had two showers in a six week period. She had a couple of bed baths, however, she just felt better if she received her showers. Her showers were supposed to be on Mondays and Thursdays. Review of the May 2020 resident care report indicated the resident received five bed baths between 5/1/20 and 5/31/20. Review of the June 2020 resident care report indicated the resident received four showers between 6/1/20 and 6/30/20 Review of the July 2020 resident care report indicated the resident received three showers between 7/1/20 and 7/23/20. The clinical record lacked documentation of any shower refusals for Resident G. b. The current activities of daily living care plan for Resident G indicated staff were to provide assistance for the resident with meals. The concern form, dated 7/10/20, the resident was not fed lunch or dinner. During an interview on 7/22/20 at 10:55 a.m., Resident G indicated a couple of weeks ago, her mother had dropped off food for her lunch meal. A staff member whom she did not recognize brought her food to her. She asked the aide if she could help her eat her lunch. The aide said she would be back to help her and never came back. At supper, she asked a different aide to help her. That aide also said she would come back but never did. She did not know who the aides were. Resident G does not eat breakfast, only lunch and supper. The resident went 24 hours without food due to lack of assistance. During an interview on 7/22/20 at 11:52 a.m., the Director of Nursing indicated the resident was not assisted with her lunch or dinner due to lack of communication between the nurse and the agency aide. On 7/23/20 at 10:15 a.m., the Director of Nursing provided a current copy of the document titled Routine Resident Care, dated 4/6/16. It included, but was not limited to, Routine Resident Care: care that in not necessarily medically or clinically based but necessary for quality of life .It is the policy of this facility to promote resident centered care .Routine care by a nursing assistant includes, but is not limited to .Assisting .eating and hydration This Federal tag relates to Complaint IN , IN 924, IN 238, and IN 450. 3.1-38(a)(2)(A)(D)
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident's (Resident F) treatments were

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.

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) completed, as ordered by the physician, for 1 of 3 residents reviewed for pressure ulcers. Findings include: The clinical record for Resident F was reviewed on 7/21/20 at 11:27 a.m. [DIAGNOSES REDACTED]. The 5 day medicare MDS (Minimum Data Set) assessment indicated the resident's cognition was intact. The care plan, dated 1/10/18, indicated the resident was at risk for pain from the sacral pressure wound and to complete dressing changes as ordered by the physician. The treatment administration record for July 2020 indicated to clean the area to the sacrum with normal saline and pat the area dry. Apply a saline moistened hydrafera blue (antibacterial wound dressing). Apply a sheet of interdry (moisture-wicking fabric) to the surrounding skin then cover with border foam every shift. During an observation and interview, on 7/23/20 at 7:20 a.m., the treatment to Resident F's bottom was dated 7/21/20 and initialed by RN 5. The RN last shift worked was 6:00 a.m. to 6:00 p.m. on 7/21/20. Resident F indicated the treatment was last completed during the day shift on 7/21/20. The July 2020 treatment administration record indicated the treatment was completed on 7/21/20 on the night shift (6:00 p.m. - 6:00 a.m.). by LPN (Licensed Practical Nurse) 3 and then on 7/22/20 during the day shift by LPN 4. During an interview on 7/23/20 at 7:45 a.m., the Director of Nursing indicated staff should not have documented the treatment as completed if the treatment was not done. The treatment administration record followed the same policy of the medication administration record. On 7/23/20 at 9:15 a.m., the Director of Nursing provided a current copy of the document titled Medication Administration, dated 5/29/19. It included, but was not limited to, Medication Administration Record [REDACTED].It is the policy of this facility to provide resident centered care .Medications will be charted when given This Federal tag relates to Complaints IN 896 and IN 238 3.1-40(a)(2)
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff immediately responded to a door alarm when a resident (Resident H), with a wanderguard in place, exited the facility, without supervision, for 1 of 3 residents reviewed for supervision. Findings include: The clinical record for Resident H was reviewed on 7/23/20 at 6:25 a.m. [DIAGNOSES REDACTED]. The 5/14/20 quarterly MDS (Minimum Data Set) assessment indicated the resident's cognition was severely impaired and daily used a wanderguard. The incident report, dated 7/15/20, indicated staff heard a door alarm sounding, immediately responded, and visualized the resident outside of the doors. The progress note, dated 7/15/20 at 8:15 p.m., indicated the nurse heard the door alarm sounding and immediately went to alarming door. LPN (Licensed Practical Nurse) 3 and LPN 4 both responded. LPN 3 went to the door alarm that was sounding and LPN 4 went to the kitchen door. LPN 4 saw the resident sitting by an unlocked car with one foot in and one foot out. The wandering observation, dated 4/16/20 at 6:53 p.m., indicated the resident had a [DIAGNOSES REDACTED]. The care plan, dated 1/17/20, indicated the resident was at risk for elopement and was to have a wanderguard to the right wrist. Place and function was to be checked every shift. During an interview on 7/23/20 at 7:10 a.m., LPN 4 indicated she heard the alarm sounding and she could not find Resident H. LPN 3 went to the staff entrance where the door alarm was sounding, turned the alarm off and looked out the door and did not see him. LPN 4 then went to the kitchen door and found the resident in the parking lot trying to get into an unlocked car. LPN 4 then brought Resident H back into the building. On 7/23/20 at 8:20 a.m., the video footage of the incident, dated 7/15/20, was viewed with the Maintenance Director. On 7/15/20 at 8:04 p.m., Resident H was observed to propel himself down the long hallway towards the staff entrance. At 8:05 p.m., the resident pushed down on the regress bar, at which time sounded the alarm. At 8:06 p.m., the resident exited into the breezeway of the staff entrance. At 8:08 p.m., LPN 4 walked around the nurse's station and sat down at the computer. At 8:10 p.m., Resident H was observed to exit out of the breezeway to the parking lot. At 8:20 p.m., LPN 3 ambulated down to the staff entrance and shut off the sounding alarm. At 8:26 p.m., LPN 4 was observed to get up from behind the nurse's station and ambulated down the hall towards the staff entrance and turned left towards the kitchen entry door. At 8:32 p.m., LPN 3 brought Resident H back in the building. During an interview on 7/23/20 at 8:35 a.m., the Maintenance Director indicated LPN 3 had gotten up to take a break and that was when she found the resident out in the parking lot. During an interview on 7/23/20 at 9:25 a.m., the Director of Nursing indicated if a door alarm is sounding, staff should assess the perimeter. On 7/23/20 at 10:20 a.m., the Director of Nursing provided a current copy of the document titled Elopement Prevention and Management Overview, dated 4/20/17. It included, but was not limited to, Definition .Elopement is defined as when a resident .leaves the premises or a safe area without authorization and/or any necessary supervision and places the resident/patient at harm or injury This Federal tag relates to Complaint IN 812 3.1-45(a)(2)