STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155659	A. Building B. Wing	04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sellersburg Healthcare Center	7823 Old State Road 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure medication carts were locked, while unattended, for 2 of 6 medication carts. Findings include:During an observation, on 4/17/26 between 1:14 p.m. and 1:18 p.m., the medication cart for the 100 Hall was observed to be unlocked and unattended. During an observation, on 4/17/26 at 1:20 p.m., the medication cart on the 300 Hall was observed to be unlocked and unattended. During an interview, on 4/17/26 at 1:22 p.m., Licensed Practical Nurse (LPN) 4 indicated the medication carts should be locked while unattended. On 4/17/26 at 2:07 p.m., the Director of Nursing provided a current copy of the document titled Storage of Medications dated 9/2025. It included, but was not limited to, Policy.Medications.are stored safely, securely, and properly.Medication.carts.are locked when not attended. 410 IAC (Indiana Authorization Code) 16.2-3.1-25(m)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure a resident's admission evaluation assessment accurately reflected wounds present on admission (Resident C); failed to ensure documentation of wound care was completed (Resident C); and failed to ensure the administration of a resident's (Resident C) narcotic pain medication was documented on the medication administration record for 1 of 4 residents reviewed for medical records. Findings include:1.a. The clinical record for Resident C was reviewed on 4/16/26 at 10:03 a.m. The resident's diagnoses included, but were not limited to, morbid obesity, anxiety and depression.The hospital discharge records indicated Resident C had an area to the coccyx, left buttock and excoriation to the abdominal folds.The facility admission evaluation assessment, dated 2/17/26 at 11:40 p.m., indicated Resident C had no skin areas noted. The assessment was completed and signed by Registered Nurse (RN) 5.The progress note, dated 2/18/26 at 11:54 a.m., indicated the Interdisciplinary Team (IDR) skin assessment indicated the resident had non-blanchable areas to the sacrum, left buttock and excoriation to the abdominal folds.During an interview, on 4/17/26 at 10:17 a.m., RN 5 indicated when residents were admitted , the admitting nurse conducted a brief skin assessment. RN 5 could not recall the resident or if wounds were present on admission.On 4/20/26 at 3:20 p.m., the Director of Nursing provided a current, undated copy of the document titled admission Evaluation. It included, but was not limited to, Policy.It is the policy of this facility to provide resident centered care.A systemic evaluation is completed by a licensed nurse upon admission/readmission to assist in determining the most effective and appropriate care needs of each resident.1(b) The clinical record for Resident C was reviewed on 4/16/26 at 10:03 a.m. The resident's diagnoses included, but were not limited to, anxiety and depression.The progress note, dated 2/18/26 at 11:54 a.m., indicated the IDT skin assessment indicated the resident had a non-blanchable areas to the sacrum, left buttock and excoriation to the abdominal folds.The physician's order, dated 2/19/26, indicated staff were to apply Calmoseptine (a multipurpose, moisture barrier ointment designed to protect and heal skin irritation) to the deep tissue injury on the left buttock three times a day at 6:00 a.m., 2:00 p.m. and 10:00 p.m.The February 2026 treatment administration record lacked documentation of the treatment completion on 2/21/26 at 2:00 p.m. and on 2/27/26 at 10:00 p.m.The physician's order, dated 2/19/26, indicated staff were to cleanse the resident's sacral wound with wound cleanser/normal saline, apply medical grade honey to the base of the wound and cover with a silicone bordered gauze three times a day a6 6:00 a.m., 2:00 p.m. and 10:00 p.m.The February 2026 treatment record lacked documentation of treatment completion on 2/21/26 at 2:00 p.m.The physician's order, dated 2/19/26, indicated the resident was to receive Oxycodone-Acetaminophen (narcotic pain medication) 10-325 mg (milligrams) every 4 hours as needed for pain.Review of the February 2026 and March 2026 controlled substance administration record indicated the resident received the medication on the following dates and times: 2/21/26 at 6:30 p.m.; 2/22/26 at 8:45 a.m.; 2/23/26 at 8:00 a.m., 12:00 p.m. and 4:00 p.m.; 2/24/26 at 2:00 a.m., 8:00 a.m. and 4:00 p.m.; 2/25/26 at 12:00 p.m. and 4:00 p.m.; 2/26/26 at 4:30 p.m. and 9:00 p.m.; 2/27/26 at 9:00 p.m.; 2/28/26 at 9:00 a.m.; 3/01/26 at 9:00 p.m.; 3/04/26 at 8:00 a.m., 4:00 p.m. and 8:00 p.m.; 3/05/26 at 12:00 a.m., 4:00 a.m., 12:00 p.m. and 4:00 p.m.; 3/06/26 at 8:00 p.m.; 3/07/26 at 5:00 a.m., 1:00 p.m. and 8:00 p.m.; 3/08/26 at 12:00 a.m., 4:00 a.m. and 8:00 p.m.; 3/09/26 at 12:00 a.m. and 4:00 a.m.; and 3/13/26 at 3:00 p.m.The February 2026 and March 2026 lacked documentation of the administration of the resident's narcotic pain medication listed above.During an interview, on 4/20/26 at 1:58 p.m., LPN 8 indicated when treatments were completed, the nurse that completed the treatment would initial the treatment administration record. When as needed (PRN) narcotic pain medication was administered, the medication would be signed out on the controlled substance administration record and on the medication administration record.On 4/20/26 at 3:20 p.m., the Director of Nursing provided a current, undated copy of the document titled Medication Administration. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	It included, but was not limited to, Definitions.Medication Administration Record - the legal documentation for medication administration.Policy.It is the policy of this facility to provide resident centered care.Procedure.Medications will be charted when given.PRN medications will have a reason documented for giving and the effectiveness of the drug.Documentation will be current for medication administration. This Citation relates to Intakes 2972337 and 2977221 410 IAC (Indiana Authorization Code) 16.2-3.1-50(a)(2)