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	12/16/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure insulin flexpens were monitored for expiration dates for 4 of 33 insulin pens reviewed. (Residents 21, 24, 112, and 94), failed to ensure the pharmacy label and open date were on eye drops for 1 of 1 resident reviewed. (Resident 56) and failed to ensure documentation on the Controlled Substance Administration Record of administered narcotics for 2 of 33 residents reviewed for medication storage. (Residents 9 and 96) Findings include:1. During an observation on 12/10/25 at 1:32 p.m., Resident 21's Glargine flexpen had an open date of 11/4/25. The handwritten expiration date indicated 12/3/25. The record for Resident 21 was reviewed on 12/10/25 at 2:15 p.m. The resident's diagnoses included, but was not limited to, type 2 diabetes mellitus and dementia. The care plan, dated 8/15/23 and revised 7/16/25, indicated the resident had diabetes. The interventions, dated 8/15/23, included, but were not limited to, administer insulin injections per orders and rotate injection sites. The physician's order, dated 7/31/25, indicated staff were to administer the resident 15 units of Glargine subcutaneously at bedtime for type 2 diabetes mellitus. The resident's blood sugar readings indicated the following: On 12/4/25 at 9:20 p.m., the resident's blood sugar reading was of 159 milligrams per deciliter (mg/dL). On 12/5/25 at 10:28 p.m., the resident's blood sugar reading was 300 mg/dL. On 12/6/25 at 4:23 p.m., the resident's blood sugar reading was 123 mg/dL. On 12/7/25 at 8:31 p.m., the resident's blood sugar reading was 175 mg/dL. On 12/8/25 at 8:45 p.m., the resident's blood sugar reading was 145 mg/dL. On 12/9/25 at 5:58 p.m., the resident's blood sugar reading was 137 mg/dL. The December 2025 Medication Administration Record (MAR) indicated the resident received Glargine daily at bedtime from 12/4/25 to 12/9/25. The Quarterly Minimum Data Set (MDS) assessment, dated 12/2/25, indicated the resident was (continued on next page)

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

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	12/16/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cognitively intact. The resident received insulin in the last 7 days before the assessment. 2. During an observation on 12/10/25 at 1:34 p.m., Resident 24's Humalog (fast acting insulin) flexpen was opened on 11/5/25. The handwritten expiration date indicated 11/21/25. The record for Resident 24 was reviewed on 12/10/25 at 2:25 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus and mild cognitive impairment. The physician's order, dated 6/20/25, indicated to administer Lispro (Humalog) insulin per sliding scale: if 151 to 200 mg/dL give 2 units; 201 to 250 mg/dL give 4 units; 251 to 300 mg/dL give 6 units; 301 to 350 mg/dL give 8 units; 351 to 400 mg/dL give 10 units. Call the physician if the blood sugar was less than 70 or greater than 400 mg/dL, subcutaneously before meals and at bedtime for diabetes. The insulin was discontinued on 12/10/25. The care plan, dated 7/3/24 and revised 12/11/25, indicated the resident had diabetes. The interventions, dated 7/3/24, included, but was not limited to, administer insulin injections per orders, and rotate the injection sites, obtain blood sugars per orders, report abnormal findings to medical provider, resident or resident representative. The November 2025 MAR indicated the resident received Humalog daily per sliding scale from 11/22/25 to 11/30/25. The December 2025 MAR indicated the resident received Humalog daily per sliding scale from 12/1/25 to 12/9/25. The Quarterly MDS assessment, dated 12/8/25, indicated the resident was severely cognitively impaired. The resident received insulin in the last 7 days before the assessment. The blood sugar readings indicated the following: On 11/22/25 at 5:02 p.m., the resident's blood sugar reading was 83 mg/dL. On 11/23/25 at 9:02 p.m., the resident's blood sugar reading was 132 mg/dL. On 11/24/25 at 11:55 p.m., the resident's blood sugar reading was 183 mg/dL. On 11/25/25 at 8:09 p.m., the resident's blood sugar reading was 165 mg/dL. On 11/26/25 at 9:11 p.m., the resident's blood sugar reading was 107 mg/dL. On 11/27/25 at 4:24 p.m., the resident's blood sugar reading was 118 mg/dL. On 11/28/25 at 8:44 p.m., the resident's blood sugar reading was 87 mg/dL. On 11/29/25 at 11:45 p.m., the resident's blood sugar reading was 82 mg/dL. On 11/30/25 at 9:22 p.m., the resident's blood sugar reading was 126 mg/dL. (continued on next page)

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	12/16/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/1/25 at 9:04 p.m., the resident's blood sugar reading was 112 mg/dL. On 12/2/25 at 9:51 p.m., the resident's blood sugar reading was 129 mg/dL. On 12/3/25 at 8:23 p.m., the resident's blood sugar reading was 97 mg/dL. On 12/4/25 at 9:19 p.m., the resident's blood sugar reading was 126 mg/dL. On 12/5/25 at 10:31 p.m., the resident's blood sugar reading was 172 mg/dL. On 12/6/25 at 3:17 p.m., the resident's blood sugar reading was 180 mg/dL. On 12/7/25 at 8:37 p.m., the resident's blood sugar reading was 115 mg/dL. On 12/8/25 at 9:15 p.m., the resident's blood sugar reading was 232 mg/dL. On 12/9/25 at 4:47 p.m., the resident's blood sugar reading was 107 mg/dL. 3. During an observation on 12/10/25 at 1:34 p.m., Resident 112's Glargine flexpen was opened on 11/5/25. The handwritten expiration date indicated 11/21/25. The record for Resident 24 was reviewed on 12/10/25 at 2:25 p.m. The resident's diagnoses included, but were not limited to, type 2 diabetes mellitus and mild cognitive impairment. The care plan, dated 10/7/25, indicated the resident had diabetes. The interventions, dated 7/3/24, included, but were not limited to, administer insulin injections per orders, and rotate the injection sites, obtain blood sugars per orders, report abnormal findings to medical provider, resident or resident representative. The physician's order, dated 11/6/25 and revised to 11/5/25, indicated staff were to administer the resident's 12 units subcutaneously of Glargine every morning for diabetes mellitus. The admission MDS Assessment, dated 11/12/25, indicated the resident was severely cognitively impaired. The resident received insulin in the last 7 days before the assessment. The physician's order, dated 12/1/25, indicated to administer 8 units subcutaneously of Glargine in the evening for diabetes mellitus. The November 2025 MAR indicated the resident received Glargine daily at bedtime from 11/22/25 to 11/30/25. The December 2025 MAR indicated the resident received Glargine daily in the evening from 12/1/25 to 12/9/25. The resident's blood sugar readings indicated the following: On 11/22/25 at 5:02 p.m., the resident's blood sugar reading was 83 mg/dL. On 11/23/25 at 9:02 p.m., the resident's blood sugar reading was 132 mg/dL. (continued on next page)

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	12/16/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/24/25 at 11:55 p.m., the resident's blood sugar reading was 183 mg/dL. On 11/25/25 at 8:09 p.m., the resident's blood sugar reading was 165 mg/dL. On 11/26/25 at 9:11 p.m., the resident's blood sugar reading was 107 mg/dL. On 11/27/25 at 4:24 p.m., the resident's blood sugar reading was 118 mg/dL. On 11/28/25 at 8:44 p.m., the resident's blood sugar reading was 87 mg/dL. On 11/29/25 at 11:45 p.m., the resident's blood sugar reading was 82 mg/dL. On 11/30/25 at 9:22 p.m., the resident's blood sugar reading was 126 mg/dL. On 12/1/25 at 9:04 p.m., the resident's blood sugar reading was 112 mg/dL. On 12/2/25 at 9:51 p.m., the resident's blood sugar reading was 129 mg/dL. On 12/3/25 at 8:23 p.m., the resident's blood sugar reading was 97 mg/dL. On 12/4/25 at 9:19 p.m., the resident's blood sugar reading was 126 mg/dL. On 12/5/25 at 10:31 p.m., the resident's blood sugar reading was 172 mg/dL. On 12/6/25 at 3:17 p.m., the resident's blood sugar reading was 180 mg/dL. On 12/7/25 at 8:37 p.m., the resident's blood sugar reading was 115 mg/dL. On 12/8/25 at 9:15 p.m., the resident's blood sugar reading was 232 mg/dL. On 12/9/25 at 4:47 p.m., the resident's blood sugar reading was 107 mg/dL. 4. During an observation on 12/10/25 at 1:36 p.m., Resident 94's Glargine flexpen was opened on 11/9/25. The handwritten expiration date indicated 12/9/25. The record for Resident 94 was reviewed on 12/15/25 at 10:26 a.m., The resident's diagnoses included, but were not limited to, type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy and end stage renal disease. The care plan, dated 4/21/25 and revised 7/28/25, indicated the resident had diabetes with retinopathy and neuropathy. The interventions, dated 4/21/25 and revised 7/28/25, included, but were not limited to, administer insulin injections per orders. Rotate the injection sites. observe for signs and symptoms of hyperglycemia, observe for signs and symptoms of hypoglycemia. Obtain and monitor lab work and diagnostic studies, as ordered. Report abnormal findings to the medical provider, resident or resident representative. The nurse's note, dated 9/8/25 at 10:11 p.m., indicated a new physician's order was received to discontinue the 12 units subcutaneously of Glargine and start 8 units subcutaneously of Glargine two times daily for diabetes mellitus. (continued on next page)

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	12/16/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Quarterly MDS assessment, dated 11/5/25, indicated the resident was cognitively intact. The resident received insulin in the last 7 days before the assessment. The physician's order, dated 12/3/25, indicated to administer 8 units of Glargine subcutaneously two times daily for diabetes. The December 2025 MAR indicated the resident received 12/10/25. The resident's blood sugar on 12/10/25 at indicated the blood sugar reading was as followed: On 10/31/25 at 5:23 p.m., the resident's blood sugar reading was 116 mg/dL. On 11/2/25 at 9:51 a.m., the resident's blood sugar reading was 148 mg/dL. On 11/2/25 at 4:53 p.m., the resident's blood sugar reading was 131 mg/dL. On 11/3/25 at 5:13 p.m., the resident's blood sugar reading was 142 mg/dL. On 11/4/25 at 9:53 a.m., the resident's blood sugar reading was 93 mg/dL. On 11/4/25 at 4:28 p.m., the resident's blood sugar reading was 117 mg/dL. On 11/12/25 at 8:28 p.m., the resident's blood sugar reading was 179 mg/dL. On 11/13/25 at 9:45 a.m., the resident's blood sugar reading was 131 mg/dL. On 11/13/25 at 8:34 p.m., the resident's blood sugar reading was 151 mg/dL. On 11/14/25 at 10:37 a.m., the resident's blood sugar reading was 115 mg/dL. On 11/15/25 at 9:30 a.m., the resident's blood sugar reading was 162 mg/dL. On 11/16/25 at 10:34 a.m., the resident's blood sugar reading was 155 mg/dL. On 11/16/25 at 9:13 p.m., the resident's blood sugar reading was 141 mg/dL. On 11/17/25 at 8:51 a.m., the resident's blood sugar reading was 188 mg/dL. On 11/17/25 at 8:11 p.m., the resident's blood sugar reading was 181 mg/dL. On 11/18/25 at 10:51 a.m., the resident's blood sugar reading was 120 mg/dL. On 11/19/25 at 11:08 a.m., the resident's blood sugar reading was 121 mg/dL. On 11/19/25 at 8:50 p.m., the resident's blood sugar reading was 199 mg/dL. On 11/20/25 at 10:43 a.m., the resident's blood sugar reading was 122 mg/dL. On 11/20/25 at 8:14 p.m., the resident's blood sugar reading was 192 mg/dL. (continued on next page)

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	12/16/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/22/25 at 11:07 a.m., the resident's blood sugar reading was 192 mg/dL. On 11/23/25 at 10:36 a.m., the resident's blood sugar reading was 103 mg/dL. On 11/23/25 at 9:04 p.m., the resident's blood sugar reading was 164 mg/dL On 11/24/25 at 7:51 a.m., the resident's blood sugar reading was 130 mg/dL. On 11/25/25 at 8:35 p.m., the resident's blood sugar reading was 223 mg/dL. On 11/27/25 at 11:00 a.m., the resident's blood sugar reading was 179 mg/dL. On 11/30/25 at 9:24 p.m., the resident's blood sugar reading was 265 mg/dL. On 12/1/25 at 8:07 a.m., the resident's blood sugar reading was 167 mg/dL. On 12/2/25 at 9:31 p.m., the resident's blood sugar reading was 132 mg/dL. 5. During an observation on 12/10/25 at 1:37 p.m., Resident 56's Latanoprost eye drops had no label with the physician's order, pharmacy information, or open date on the bottle. There was no box available for the eye drops. The eye drops can be used for 42 days after opening. During an interview on 12/10/25 at 1:56 p.m., RN 9 indicated she should verify the order for the eye drops, note the expiration date, check the resident information, and check the Medication Administration Record. She indicated she just threw away the eye drop bottle due to not having the physician's order with the eye drop bottle. The record for Resident 56 was reviewed on 12/15/25 at 8:35 a.m. The resident's diagnoses included, but were not limited to, seasonal allergic rhinitis and hypertension. The physician's order, dated 3/5/24, indicated staff were to administer the resident 1 drop of Latanoprost in both eyes at bedtime for dry eyes. The care plan, dated 3/17/24 and revised 3/27/25, indicated the resident had hypertension and hyperlipidemia. The interventions, dated 3/17/24, included, but were not limited to, Administer medications per medical provider's orders. Observe for side effects and effectiveness. Report abnormal findings to medical provider, the resident and resident representative. Observe for signs or symptoms of elevated blood pressure. Report any abnormal findings to the medical provider, the resident or resident representative. Obtain and monitor lab work and diagnostic studies, as ordered. Report abnormal findings to the medical provider, the resident or resident representative. The November 2025 MAR indicated the resident received Latanoprost eye drops between 11/1/25 and 11/30/25. The Quarterly MDS assessment, dated 11/5/25, indicated the resident was moderately cognitively impaired. The December 2025 MAR indicated the resident received Latanoprost eye drops 12/1/25 and 12/9/25 (continued on next page)

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	12/16/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/10/25 at 1:37 p.m., RN 10 indicated she should check the expiration dates on medication before administering it. She never signed out medications until she administered them. 6. The record for Resident 9 was reviewed on 12/10/25 at 12:30 p.m., the resident's diagnoses included but were not limited to, surgical aftercare following surgery on the digestive system, and diverticulitis of the intestine with perforation abscess. The physician's order, dated 12/3/25 at 2:00 p.m., indicated the resident was to receive oxycodone HCl (hydrochloride) oral tablet 5 mg. Give 1 tablet every 4 hours for chronic pain. The care plan, dated 8/19/25, indicated the resident had complaints of acute and chronic pain. The interventions included, but were not limited to, administer non-pharmacological interventions and evaluate the effectiveness of the interventions (repositioning, diversion activities, snacks and fluids, ice / heat, music therapy, relaxation techniques, imagery), complete a pain assessment on admission / re-admission, quarterly, significant change, and as needed, (PRN) follow the physician orders for complaint of pain, and notify the medical provider, and the resident representative if interventions are unsuccessful. The admission MDS assessment, dated, 9/17/25 indicated the resident was cognitively intact. During an observation on the 100 unit, on 12/10/25 at 11:30 a.m., Licensed Practical Nurse 11 (LPN) was observed bringing a pain pill into Resident 9. She indicated here is your pain pill I forgot to give it to you. The resident was to receive a Hydrocodone 5 milligram (mg) every 4 hours for chronic pain at 10:00 a.m. During the Narcotic count on 12/10/25 at 12:30 p.m., the nurse had signed out the oxycodone HCl 5 mg at 10:00 a.m. as given. 7. The record for Resident 96 was reviewed on 12/10/25 at 1:00 p.m. The diagnoses included but were not limited to, anoxic brain damage, acute respiratory failure with hypoxia, dependence of a ventilator, tracheostomy, and anxiety. The physician order, dated 11/26/25, indicated diazepam 10 mg, give 2 tablets via her gastrostomy tube 2 times a day for anxiety. The care plan, dated 6/2/25 and revised on 10/14/25, indicated the resident was on anti-anxiety medication related to anxiety. The interventions included, but were not limited to, maintain a consistent daily routine, when possible, observe for side effects of the medication, and provide anti-anxiety medication per medical provider's orders. The review of the Quarterly MDS, dated [DATE], indicated the resident was severely cognitively impaired. During a narcotic count, on 12/10/25 at 1:30 p.m., on the 400 unit the count indicated for Resident 96 had 16 Diazepam 10 mg left on the card. The narcotic sign out sheet indicated the resident had 14 Diazepam 10 mg left. LPN 12 had signed out 2 Diazepam 10 mg as given to the resident at 8:00 a.m. The LPN indicated she signed out the medication on the narcotic sign out record and she forgot to give the medication. (continued on next page)

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	12/16/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 12/16/25 at 8:37 a.m., the Regional Director of Clinical Operations (RDCO) indicated the narcotics should be signed out when the nurse pulled the narcotic out of the lock box and ready to give the medication. During an interview, on 12/16/25 at 9:00 a.m., LPN 13 indicated when giving a narcotic medication she would sign out the narcotic when she pulled the medication from the narcotic box. A narcotic should not be signed out until the medication was removed and time given. The current Medication Administration policy included, but was not limited to, .z. Do not administer medication of the label is not legible or missing aa. For medications that expire, label the date opened on the label (insulin, irrigation solutions etc.) ee. Narcotics will be signed out when given ff. Medications will be administered within the time frame of one hour before up to one hour after time ordered . 3.1-25(b)(1)(c) 3.1-25(n) 3.1-25(0)

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	12/16/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on record review and interview, the facility failed to ensure residents received a minimum of a shower or bed bath twice weekly. This deficient practice affected 2 of 99 residents reviewed for Activities of Daily Living (ADLs). (Residents 2 and 14).Findings include During the Resident Council meeting, on 12/11/25 at 2:30 p.m.,. with 8 residents, which the Activities Director indicated were alert and oriented, several residents indicated they were not getting their showers twice weekly according to the shower schedules. No explanations were given by the Certified Nurse Aides (CNAs) or they were told the residents the next shift or the next day, a shower would be given. The residents indicated this was not happening.1.The record for Resident 2 was reviewed on 12/11/25 at 11:00 a.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), paranoid schizophrenia, major depressive disorder, anxiety disorder, drug induced subacute dyskinesia, chronic pain, and mild neurocognitive disorder due to known physiological condition without behavioral disturbance.The Quarterly Minimum Data Set (MDS) assessment, dated 12/1/25, indicated the resident had moderate cognitive impairment with long and short term memory issues, had no behavioral issues, and required partial to moderate assistance with showering.A care plan, dated 1/20/23 with a revision date of 12/3/25, indicated the resident had a problem with a decline in her ADLs due to COPD with schizophrenia and dyskinesia. The goal was for the resident to be without a decline in Range of Motion (ROM). The approaches included, but were not limited to, required partial to moderate assistance with showering or bathing self; and required partial to moderate assistance with tub or shower transfers.A review of the shower sheets, from 9/15/25 through 12/8/25, indicated the following days had no check off as to whether the resident received a shower or not: 9/15/25, 9/22/25, 9/29/25, 10/9/25, 10/13/25, 10/16/25, 10/20/25, 10/23/25, 10/30/25, 11/3/25, 11/10/25, 11/17/25, 11/20/25, 11/24/25, 12/1/25, 12/4/25, and 12/18/25.During an interview with the Director of Nursing (DON) and the Regional Director of Clinical Operations (RDCO), on 12/15/25 at 8:15 a.m., the DON indicated that if the CNAs signed their name to the section on skin checks, then the resident received a shower. Even if they did not check off on the sheet whether the resident received a shower, it was assumed a shower was given. The CNAs were required to let the nurses know if a resident refused a shower as the nurse would need to evaluate the resident as to why he/she refused a shower. The nurse would then sign the shower sheet, which indicated she reviewed the resident and documented the refusal in the clinical record. Review of the resident's record, from 9/1/25 through 12/10/25, indicated the documentation was lacking as to whether the resident refused a shower or bed bath.During an interview with Resident 2, on 12/11/25 at 10:28 a.m., she indicated she was not always getting her showers as scheduled. She did not know why they frequently skipped her.2. During the Resident Council meeting on 12/11/25 at 2:30 p.m., Resident 14 indicated she frequently had to ask the CNAs if she was going to get her shower or not. Shower days were Sunday and Thursday. She indicated the CNA gave her a bed bath today instead.The record for Resident 14 was reviewed on 12/15/25 at 11:40 a.m. The resident's diagnoses included, but were not limited to, end stage renal disease (ESRD), bipolar disorder, and dependence on renal dialysis.The admission MDS assessment, dated 9/25/25, indicated the resident was alert and oriented but required cues to answer questions appropriately at times; had no mood or behavior issues; required substantial to maximum assistance for showers; required substantial to maximum assistance for bathing herself and showering; and required partial to moderate assistance for personal hygiene.A care plan, dated 9/18/25 with a revision date of 10/7/25, indicated the resident had an ADL self performance deficit due to impaired mobility, The goal was for the resident to improve her current level of function. The approaches included, but were not limited to, substantial to maximal assistance to bath and shower self, and required partial to moderate assistance for personal hygiene. The review of the shower sheets, from 9/21/25 through 12/7/25, indicated the following days had no check off as to whether the resident received a shower or not: 9/21/25, 9/28/25, (continued on next page)

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	12/16/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/5/25, 10/9/25, 10/12/25, 10/16/25, 10/19/25, 10/23/25, 10/26/25, 10/30/25, 11/2/25, 11/4/25, 11/9/25, 11/13/25, 11/16/25, 11/20/25, 11/23/25, 11/27/25, 11/30/25, 12/4/25, and 12/7/25. Review of the record's progress notes, from 9/18/25 through 12/14/25 indicated there was no documentation of the resident having refused a bed bath or shower. During an interview, on 12/15/25 at 11:10 a.m., CNA 4 indicated the shower sheets were filled out checking Accept or Refusal whenever a resident received their showers. If the form was not marked as having a shower, then one would have to the resident and ask them. The shower days for the residents were hanging in the clean linen room. During an interview, on 12/15/25 at 11:15 a.m., CNA 5 indicated the shower sheets were marked as to whether the resident had a shower or refused. If they were not marked, then one would have to talk to the CNA who was caring for the resident or the resident themselves.During an interview, on 12/15/25 at 11:25 a.m., CNA 6 indicated the shower sheets were completed as Accept or Refusal and there was a shower list that was followed twice weekly for each resident. If it was not marked, then one would have to ask the resident if they received a shower that day.On 12/15/25 at 10:15 am, the RDCO presented a copy of the facility's current policy on Routine Resident Care. The policy included, but was not limited to, Procedure: 2. Provide routine care by a certified nursing assistant with specialized training in rehabilitation/restorative care under the supervision of a licensed nurse including but not limited to: .g. Assisting and teaching activities of daily living 3. Unlicensed staff: a. Provide routine daily care by a certified nursing assistant under the supervision of a licensed nurse. b. Routine care by a nursing assistant includes but is not limited to the following: 3.1-38(a)(2)(A)3.1-38(b)(2)

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	12/16/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a resident with a history of Urinary Tract Infection (UTIs) was provided proper management of the urinary catheter drainage system by maintaining the drainage system off the floor for 2 of 4 residents reviewed for bowel and bladder. (Residents 106 and 7)Findings include:1. During an observation, on 12/9/25 at 9:15 a.m., Resident 106 was lying in her bed. Resident 106's urinary catheter bag was 2/3 full of urine which was sitting on the floor. The tubing was also lying on the floor with yellow urine and sediment in the tubing. There was no barrier between the catheter and the floor.During an observation, 12/15/25 at 12:52 p.m., Resident 106 was lying in her bed on her back. The urinary catheter drainage system was sitting on the floor with 1/3 full of dark yellow urine. The tubing was also lying on the floor with dark yellow urine. The resident's bed had been lowered down as far as it could go. There was no barrier between the catheter and the floor.During an observation of incontinence care, on 12/11/25 at 11:18 a.m., for Resident 106 by Certified Nurse Aides (CNAs) 7 and 8. Both CNAs performed hand hygiene and PPE (personal protective equipment) was applied. The catheter bag was placed at the foot of the bed. The resident's brief was unfastened. CNA 8 used wipes and swiped the perineum front to back. She obtained a clean wipe and with 2 swipes down the tubing, she cleaned the tubing. The resident was turned onto her right side, and the rectal area was cleaned. CNA 8 indicated that they typically do not place briefs on the resident, however they were told by nursing to use the brief due to the catheter leaking a small amount. CNA 8 removed her gloves and used hand sanitizer. She applied fresh gloves. CNA 8 lifted the catheter bag to CNA 7 by lifting it above the resident's bladder and placed it on the left side of the bed. Urine was observed flowing up the tubing, toward the resident while it was lifted. The CNAs removed their PPE and performed hand hygiene.The record for Resident 106 was reviewed on 12/9/25 at 10:25 a.m. The resident's diagnoses included, but were not limited to, neuromuscular dysfunction of the bladder, cerebral infarction, carrier of carbapenem-resistant acinetobacter baumannii, a need for assistance with personal care.The care plan, dated 6/10/24 and revised 8/4/25, indicated the resident had an indwelling catheter for neurogenic bladder. The interventions, dated 6/10/24, included, but were not limited to, provide catheter care every shift and as needed (PRN), monitor for pain, fever, chills, purulent drainage or other signs and symptoms of a urinary tract infection (UTI), change drainage bag, and ensure securement device in place.The care plan lacked documentation of any interventions related to placing a barrier between the catheter collection bag and the floor.A physician's order, dated 11/27/25, indicated the resident was to have an indwelling catheter #16 french with a 10 milliliter (ml) [NAME] for continuous drain due to the diagnosis of neurogenic bladder.A physician's order, dated 11/27/25, indicated the resident was to have indwelling catheter tubing using an anchoring device to prevent movement and urethral traction.A physician's order, dated 11/27/25, indicated the resident was to have indwelling urinary Catheters output to be measured and recorded every shift.A physician's order, dated 11/27/25, indicated the resident was to have indwelling urinary catheter care every shift and PRN with soap and water.A physician's order, dated 11/27/25, indicated the resident was to have the indwelling urinary catheter changed as needed once per day.A physician's order, dated 11/28/25, indicated the resident was prescribed Daptomycin 500 milligram (MG) (antibiotic) intravenously one time a day for UTI for a duration of 6 weeks.A physician's order, dated 11/28/25, indicated the resident was prescribed Ceftolozane-Tazobactam 1.5 (1-0.5) grams (antibiotic) intravenously every 8 hours for UTI for a duration of 6 weeks.An alert charting progress note, dated 11/28/25 at 9:32 a.m., indicated the resident was on intravenous (IV) antibiotics due to having a UTI.A physician's order, dated 12/5/25, indicated the resident was to be in enhanced barrier precautions due to medical devices and the resident' s history of carbapenem-resistant acinetobacter baumannii (CRAB) bacteria, (continued on next page)

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	12/16/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Carbapenem-resistant Pseudomonas aeruginosa (CRPA) and Candida auris (C. auris).During an interview, on 12/16/25 at 8:34 a.m., the Regional Director of Clinical Operations indicated that there should be a barrier between a catheter collection bag and the floor.During an interview, on 12/16/25 at 9:30 a.m., the Infection Preventionist (IP) indicated that there was no reason that a catheter collection bag should be on the floor. The IP indicated that she had repeatedly told nursing staff to put a wash basin under the catheter collection bag if it was on the floor.2. During an observation, on 12/9/25 at 9:30 a.m., Resident 7 was lying in bed on her left side. The urinary catheter drainage system was sitting on the floor with the collection bag 1/2 full of urine. There was no barrier between the catheter and the floor. During an observation, on 12/9/25 at 1:55 p.m., Resident 7 was lying in bed on her right side. The urinary catheter drainage system was sitting on the floor with a minimal amount of urine in the collection bag. There was no barrier between the catheter and the floorThe record for Resident 7 was reviewed on 12/12/2025 at 10:42 a.m. The resident's diagnoses included, but were not limited to, neuromuscular dysfunction of bladder, brain stem stroke syndrome, need for assistance with personal care, and locked-in state.The care plan, dated 2/27/25 and no revision, indicated the resident had an indwelling catheter due to having neurogenic bladder. The interventions, dated 2/27/25, included, but were not limited to, provide catheter care every shift and PRN, position catheter bag and tubing below the level of the bladder and provide privacy bag, secure catheter to the leg with security device, observe, record, report to the doctor signs of UTI, enhanced barrier precautions when providing care to urinary catheter, change catheter per physician order and PRN, and change drainage bag per physician order and PRN.The care plan lacked documentation of any interventions related to placing a barrier between the catheter collection bag and the floor.The Discharge Minimum Data Set (MDS) assessment, dated 11/14/25, indicated the resident was severely cognitively impaired. The resident has an indwelling foley catheterA physician's order, dated 12/5/25, indicated the resident was to have indwelling urinary catheter care every shift and PRN with soap and water. Secure straps to securement device and document output of urine every shift.A physician's order, dated 12/5/25, indicated the resident was to have an indwelling catheter #16 french with a 10 ml balloon for continuous drain due to the diagnosis of neurogenic bladder. The order also was written for the indwelling urinary catheter to be in a privacy bag.A physician's order, dated 12/5/25, indicated the resident was to have the indwelling urinary catheter changed as needed once per day.The urinalysis results, dated 12/8/25 and reported 12/9/25, indicated the urine had 2 plus blood, 3 plus leukocytes, 2.0-3.0 Urobilinogen, 1 plus protein, and 2 plus bacteria. The culture results indicated no growth. A physician's order, dated 12/9/25, indicated the resident was to be in enhanced barrier precautions due to medical devices and the resident's history of CRPA.A nurse's note, dated 12/9/25 at 1:58 p.m., indicated that an order by the facility nurse practitioner (NP) was for Rocephin 1 gm by intramuscular injection for three days (antibiotic), secure a peripheral intravenous placement and start normal saline IV fluids to run at 100 millimeters (ML) for 1 liter of fluids related to leukocytosis and fever. A nurse's note, dated 12/9/25 at 2:12 p.m., indicated that a 22 gauge (G) IV catheter was placed in the resident's hand. The IV Fluids were started at 100 ml/hr.A nurse's note, dated 12/9/25 at 5:24 p.m., indicated that the facility NP gave an order to contact the hospice company to evaluate and treat the resident.A nurse's note, dated 12/11/25 at 8:35 p.m., indicated that the resident was found without a pulse and was non-responsive. The resident was followed by hospice and was a do not resuscitate (DNR). The resident's status was verified by 2 nurses and the respiratory therapist. The Catheter Drainage Bag and Tube Maintenance policy was provided by the Regional Director of Clinical operations on 12/16/25 at 9:00 a.m. It included: It is the policy of this facility to provide resident care that meets the psychosocial, physical, and emotional needs and concerns of the residents.Procedure: Catheter Bags and tubing. I. Drainage bags will not be placed on the floor.3.1-41 (a) (1)