

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155319	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/12/2016
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NAME OF PROVIDER OR SUPPLIER CLINTON GARDENS	STREET ADDRESS, CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN 47842
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F 0000 Bldg. 00	<p>This visit was for Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00204127.</p> <p>Survey dates: July 5, 6, 7, 8, 11, and 12, 2016</p> <p>Facility number: 000212 Provider number: 155319 AIM number: 100285040</p> <p>Census bed type: SNF/NF: 86 Total: 86</p> <p>Census payor type: Medicare: 13 Medicaid: 43 Other: 30 Total: 86</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by 21662 on July 15, 2016.</p>	F 0000	The filing of this plan of correction does not constitute an admission that the deficiencies alleged did in fact exist. The plan of correction is filed as evidence of the community's desire to comply with the requirements and to continue to provide a safe and functional environment for our residents. Clinton Gardens would like to respectfully request a desk review of the following plan of correction.	

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 0241 SS=D Bldg. 00	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were provided a dignified dining experience for 1 of 1 dining observations in assisted dining room. (Residents #25)</p> <p>Finding includes:</p> <p>During a continuous observation on 7/5/16 from 12:01 p.m., to 12:12 p.m., LPN # 3 stood over Resident # 25 as she fed him is lunch meal.</p> <p>During an interview on 7/11/16 at 2:39 p.m., the CNA (certified nurse aide) # 1 indicated staff were not to stand over residents to feed them in the dining room.</p> <p>During an interview on 7/12/16 at 10:16 a.m., the DON (director of nursing) indicated staff should not stand over residents to feed them in the dining room.</p> <p>A current document titled, "Resident Rights," was provided by the DON on 7/12/16 at 10:40 a.m. The document</p>	F 0241	<p>-1 resident was affected by thepractice.</p> <p>-All residents receiving assistancewith meals have the potential to be affected.</p> <p>-The employee involved immediatelyinserviced. All other nursing staffinserviced on correct methods to assist residents with dignity. DNS will educate during all staff inserviceon 7/26/16.</p> <p>- The Director of Nursing/designee will completethe Meal Service Observation QA tool weekly x four, bi-monthly x two months,and quarterly thereafter. The results of these audits will bereviewed by the QAPI committee overseen by the ED. If threshold of 100% is notachieved, an action plan will be developed to ensure compliance.</p>	07/29/2016

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F 0278 SS=D Bldg. 00	<p>indicated, "...(a) Dignity. The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or his individuality...."</p> <p>3.1-3(t)</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money</p>			

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	<p>penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on record review and interview, the facility failed to ensure the accuracy of the unhealed pressure ulcers used for the coding of the Discharge Minimum Data Set (MDS) Assessment for 1 of 3 residents reviewed with pressure ulcers (Resident # 6).</p> <p>Finding includes:</p> <p>On 7/8/16 at 10:00 a.m., review of Resident #6's medical record indicated the resident's diagnoses included, but were not limited to, type 2 diabetes mellitus, spinal stenosis, and hemiplegia and hemiparesis following CVA (cerebrovascular accident) affecting left non dominant side.</p> <p>Pressure wound skin evaluation report, dated 5/31/16, indicated Resident # 6 had a stage 2 (partial thickness loss of skin layers that present clinically as an abrasion, blister, or shallow crater) pressure ulcer to superior right buttock. Area measures 1.2 cm (centimeter) x 0.3</p>	F 0278	<p>-Resident #26 , MDS was modified to includeaccurate pressure wounds on 7/8/16.</p> <p>- Allresidents that have had pressure wound have the potential to be affected bysame alleged deficient practice.</p> <p>- RAI Specialist/designee willcomplete 100% audit of residents that have had pressure wound, to ensure properMDS coding by 7/29/16. An inservicewill be completed by RAI Specialist with MDSC on 7/27/16 regardingaccuracy of MDS coding.</p> <p>-The MDS will be reviewed foraccuracy during the weekly IDT care plan review utilizing the care plan reviewtool by the MDSC/designee.</p> <p>- The MDS Accuracy QA Audit Tool will be completed for six monthswith audits being completed once weekly for one month and monthly for 5 monthsby the MDSC/designee.The MDS Accuracy QA Audit Tool will be reviewed monthly bythe CQI Committee for six months after which the CQI team will re-evaluate thecontinued need</p>	07/29/2016

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	<p>cm x 0.1 cm in size.</p> <p>Pressure wound skin evaluation report, dated 5/31/16, indicated Resident # 6 had a stage 2 pressure ulcer to inferior right buttock . Area measures 1.0 cm x 1.0 cm x less than 0.1 cm in size.</p> <p>Pressure wound skin evaluation report, dated 6/7/16, indicated Resident # 6 had a Stage 3 (full thickness of skin is lost, exposing the subcutaneous tissue) pressure ulcer to sacrum. Area measures 3.0 cm x 5.3 cm x less than 0.1 cm in size.</p> <p>A review of Resident #6's Minimum Data Set (MDS) Assessment, dated 6/7/16, Section M (M0300) titled, "Current Number of Unhealed Pressure Ulcers at Each Stage" indicated a code of 1 pressure ulcer Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with red or pink wound bed, without slough...."</p> <p>During an interview with MDS Coordinator, on 7/8/16 at 1:38 p.m., she indicated Resident # 6's MDS assessment that was completed on 6/7/16, was not coded correctly. She further indicated it should have been coded as resident had (2) stage 2 and (1) stage 3 unhealed pressure ulcers.</p>		<p>for the audit. If a 100% threshold is not achieved an actionplan will be developed. Deficiency in this practice will result in disciplinaryaction up to and including termination of the responsible employee.</p>		

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F 0371 SS=E Bldg. 00	<p>On 7/11/2016 at 2:22 p.m., the DON (Director of Nursing) indicated the 6/7/16 MDS pressure ulcer assessment was coded incorrectly. The MDS assessment should have been coded as Resident # 6 had (2) stage 2 and (1) stage 3 unhealed pressure ulcer.</p> <p>The MDS Coordinator on 7/8/16 at 1:48 p.m., provided copies of the Center for Medicare Services (CMS) Resident Assessment Instrument (RAI), Version 3.0 Manual, indicated, "...Code for the most severe type of tissue present in the pressure ulcer wound bed... M0300 Current Number of Unhealed Pressure Ulcers at Each Stage...."</p> <p>3.1-31(d)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure meals were served under sanitary</p>	F 0371	<p>-No residents were affected by the deficiency. -All residents have the potential to be affected by the deficient practice.</p>	07/29/2016
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	<p>conditions in the main dining room for 38 of 38 residents who received meals in the main dining room.</p> <p>Findings include:</p> <p>During a dining observation on 7/5/16 at 11:59 a.m., Activities Assistant #6 was observed twice to wash her hands, turn off the faucet with her bare hand, and then proceeded to serve residents in the main dining room plates of food.</p> <p>On 7/5/16 at 12:02 p.m., Activities Assistant #7 was observed three times to wash her hands, turn off the faucet with her bare hand, and then proceeded to serve residents in the main dining room plates of food.</p> <p>On 7/5/16 at 12:09 p.m., CNA (Certified Nursing Assistant) #8 was observed to wash her hands, turn off the faucet with her bare hand, and proceeded to serve residents in the main dining room plates of food.</p> <p>On 7/5/16 at 12:16 p.m., CNA #9 was observed to wash her hands, turn off the faucet with her bare hand, and proceeded to serve residents in the main dining room plates of food.</p> <p>The DON (Director of Nursing) on</p>		<p>-Employees involved immediately inserviced on properhandwashing procedures. DNS will educateall staff on handwashing at 7/26/16 all staff inservice.</p> <p>-The Director of Nursing/designee will complete the MealService Observation QA tool weekly x four, monthly x two months, and quarterlythereafter. The results of these audits will be reviewed by theQAPI committee overseen by the ED. If threshold of 100% is not achieved, anaction plan will be developed to ensure compliance.</p>	

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F 0465 SS=E Bldg. 00	<p>7/12/16 at 10:16 a.m., indicated, when handwashing, staff should turn off the faucet with a paper towel to properly wash their hands and maintain infection control.</p> <p>A policy, titled "HAND HYGIENE," identified as current and dated 12/2015, provided by the DON on 7/12/16 at 10:20 a.m., indicated, "...Handwashing...Use towel to turn off faucet...Five moments for Hand Hygiene, Before touching a patient, Before Clean/Aseptic procedure, After body fluid exposure risk, After touching a patient, After touching a patient surroundings...."</p> <p>3.1-21(i)(3)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure living environments were functional and comfortable for 6 of 35 resident rooms reviewed for comfortable living environments. (Rooms #4, #6, #11, #20,</p>	F 0465	<p>-All residents residing in identified rooms affected. -All residents have the potential to be affected by the deficient practice. -Maintenance immediately notified of the areas needing repairs. All areas to be</p>	07/29/2016

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	<p>#29, and #40).</p> <p>Findings include:</p> <p>On 7/12/16 at 2:44 p.m., during an environmental tour with the Maintenance Director, the following issues were observed:</p> <p>a. Room #4: Black scuff marks were observed on the right side bathroom wall.</p> <p>b. Room #6: Three deep gouges were observed on the wall to the right of head of bed B. A marred area, measured 18 inches by the Maintenance Director, with exposed drywall was observed on the wall across from the toilet, in the resident's bathroom.</p> <p>c. Room #11: The vent cover above the covebase and to the left of the head of bed A was unattached from the wall.</p> <p>d. Room #20: A chipped area with sharp edges was observed on the lower portion of the interior of the entrance door.</p> <p>e. Room #29: A marred/scuffed area, measured 29 inches by the Maintenance Director, was observed on the wall next to bed B, and unpainted patches were observed in the resident's bathroom.</p>		<p>repaired by 7/29/16.</p> <p>-Room rounds to be completed for environmental concerns weekly x4 weeks, bi-weekly x4 weeks and monthly x 2 months. All concerns will be brought to CQI and addressed immediately. ED will monitor for compliance.</p>				

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	<p>f. Room #40: A marred/scuffed area, measured 9 inches by the Maintenance Director, was observed on the wall on the door side of the resident's bathroom.</p> <p>During an interview on 7/12/16 at 3:10 p.m., the Maintenance Director indicated he was not aware of any of the issues that were observed during the environmental rounds. He indicated when maintenance issues were observed by staff, a repair requisition form would be completed and placed in his mailbox or slid under the door to the maintenance office. He indicated he checked for the forms each day and reviewed them as they were received. He indicated the work requisitions were prioritized and acted upon immediately.</p> <p>A current policy titled, "Maintenance Department," dated 2/2012, was provided by the Administrator on 7/12/16 at 3:56 p.m. The policy indicated, "Policy: The Maintenance Department shall maintain optimal conditions to maintain a safe and healthy environment...Components: ...3. Repairs: a. Scheduled rounds of facility to perform routine maintenance and identify problems or needed repairs..."</p> <p>3.1-19(f)</p>			