

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155697	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/14/2015
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NAME OF PROVIDER OR SUPPLIER  CLARK REHABILITATION AND SKILLED NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaints IN00179221 and IN00179607.</p> <p>Complaint IN00179221 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157 and F514.</p> <p>Complaint IN00179607 - Substantiated. Federal/State deficiencies related to the allegations are cited at F323.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: August 12, 13 and 14, 2015</p> <p>Facility number: 000059 Provider number: 155697 AIM number: 100266560</p> <p>Census bed type: SNF/NF: 72 Total: 72</p> <p>Census payor type: Medicare: 14 Medicaid: 50 Other: 8 Total: 72</p>	F 0000		
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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 0157 SS=D Bldg. 00	<p>Sample: 4</p> <p>These deficiencies reflect State findings cited in accordance with 401 IAC 16.2-3.1.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p>			

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	<p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify the physician and pharmacy of an unavailable medication, Xarelto (medication used for atrial fibrillation), for 1 of 4 residents reviewed for physician notification. (Resident #B)</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 8/12/15 at 1:00 p.m. Diagnosis included, but was not limited to, atrial fibrillation.</p> <p>The document titled, "Anticoagulant Administration History", included, but was not limited to, the following: "...Xarelto...Amount to Administer: 15 mg [milligrams]...[DX [diagnosis]: Fibrillation, atrial]...7/16/15...Not Administered: Drug/Item unavailable...7/17/15...Not Administered: Drug/Item unavailable...7/18/15...Not Administered: Drug/Item unavailable...."</p> <p>As of the date/time of record review, the clinical record for Resident #B lacked physician and pharmacy notification regarding the unavailability of the Xarelto.</p>	F 0157	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>·Residents B did not have a negative outcome related to the alleged deficient practice and the physician and pharmacy have been notified. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</li> <li>·All residents have the potential to be affected by the alleged deficient practice.</li> <li>·In-service on physician and pharmacy notification conducted for nursing staff and all new hire nursing staff by CEC/Designee by 9/13/15. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</li> <li>·In-service on physician and pharmacy notification conducted for nursing staff and all new hire nursing staff by CEC/Designee by 9/13/15.</li> <li>·Nurse Managers/Designee will review EMR compliance report each shift to ensure physician and pharmacy notification is made per guidelines.</li> </ul> <p><b>How the corrective action(s) will be maintained to ensure the</b></p>	09/13/2015

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	<p>During an interview on 8/13/15 at 3:10 p.m., the DON (Director of Nursing) indicated, if a medication was not available, the nursing staff should check the Pyxis (automated medication dispensing system) for the medication. The DON also indicated, if the medication is not available in the Pyxis, the pharmacy and physician should be notified.</p> <p>During an interview on 8/14/15 at 9:30 a.m., the ADON (Assistant Director of Nursing) indicated the facility did not have the Xarelto in the Pyxis and the physician and pharmacy were not notified regarding the unavailability of the Xarelto.</p> <p>During an interview on 8/14/15 at 12:05 p.m., the facility Nurse Practitioner indicated he should have been notified regarding the unavailability of the Xarelto.</p> <p>The pharmacy policy and procedure, dated 2/2014, was provided by the Administrator on 8/14/15 at 11:40 a.m. This policy included, but was not limited to, the following: "...Title: STAT Order Requests...Purpose: to define the process utilized to initiate a STAT order from the pharmacy...Procedure: 1. If a resident</p>		<p><b>deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>·To ensure compliance, the DNS/Designee is responsible for the completion of the Pharmacy Services CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</li> <li>·Nurse Managers/Designee will review EMR compliance report each shift to ensure physician and pharmacy notification is made per guidelines.</li> <li>·DNS/Designee will review progress notes for all shifts daily for one week, bi weekly for 1 week, weekly times 2 weeks, and monthly for six months to monitor appropriate physician and pharmacy notification.</li> <li>·Attachments <ul style="list-style-type: none"> <li>·A, A1, B, C, D</li> <li>·September 13, 2015</li> </ul> </li> </ul>	

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F 0272 SS=D Bldg. 00	<p>requires an essential medication prior to the next scheduled delivery, the nurse should contact the pharmacy to request a STAT delivery. 2. Essential medications may include, but are not limited to...2.3. Cardiac medications...3. Pharmacy staff is available twenty-four (24) hours a day, seven (7) days a week to process STAT orders. 4. The nurse should initiate the process by calling the pharmacy to request a STAT...6. The pharmacy will STAT medication orders when essential medications are required...."</p> <p>This Federal tag relates to the Investigation of Complaint IN00179221.</p> <p>3.1-5(a)(3)</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine;</p>			

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	<p>Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continance; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, interview and record review, the facility failed to ensure the MDS (Minimum Data Set) assessment accurately reflected a resident's Foley catheter (urinary catheter) for 1 of 2 residents reviewed for Indwelling catheters. (Resident #E)</p> <p>Findings include:</p> <p>The clinical record for Resident #E was reviewed on 8/13/15 at 11:00 a.m. Diagnosis included, but was not limited to, neurogenic bladder. The most recent MDS significant change assessment, dated 6/6/15, indicated Resident #E was</p>	F 0272	<p><b>F-272 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>·Resident E did not have a negative outcome related to the alleged deficient practice.</li> <li>·Resident E's 6/6/15 significant change MDS was modified to add foley catheter on 8/27/15.</li> <li>·Resident E's foley catheter care plan was added on 8/13/15.</li> </ul> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <ul style="list-style-type: none"> <li>·All residents have the potential to be affected by the alleged</li> </ul>	09/13/2015

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	<p>incontinent of bladder.</p> <p>On 8/13/15, at 10:25 a.m., Resident #E was observed sitting on the side of the bed with a Foley catheter to bedside drainage in place.</p> <p>A physician's order for Resident #E, dated 6/2/15, included, but was not limited to, the following: "...Order Description: Cath [catheter] orders: Foley catheter...Size 14fr [french] 10 ml [milliliters]...Diagnosis...Neurogenic bladder...."</p> <p>On 8/13/15 at 3:55 p.m., the Administrator provided a copy of the Minimum Data Set Assessment, dated 6/6/15. It included, but was not limited to, the following: "[Resident # E's name]...Section H...Bladder and Bowel...Appliances...A. Indwelling catheter...Z. None of the above [marked with an x]...Urinary Continence...3. Always incontinent..." The MDS indicated Resident #E had none of the above</p> <p>During an interview on 8/13/15 at 3:15 p.m., the DON (Director of Nursing) indicated the 6/6/15 MDS significant change assessment was incorrect.</p> <p>3.1-31(a)</p>		<p>deficientpractice.</p> <ul style="list-style-type: none"> <li>·Entire facility audit conducted 8/27/15 on MDSs coded for foley catheteron last MDS to ensure all are coded correctly and have corresponding careplans.</li> <li>·In-service on accurate foley catheter coding and care planning conductedfor MDS staff 8/27/15 by MDS Specialist.</li> <li>·In-service on Temporary Admission Care Plan and Care Plan Updatingconducted for MDS staff 8/31/15 by ED.</li> <li>·In-service on IDT Admission/Readmission Review and Care PlanInitiation/Update conducted for IDT Team on 8/31/15 by ED. What measures will be putinto place or what systemic changes will be made to ensure that the deficientpractice does not recur?</li> <li>·In-service on accurate foley catheter coding and care planning conductedfor MDS staff 8/27/15 by MDS Specialist.</li> <li>·In-service on Temporary Admission Care Plan and Care Plan Updatingconducted for MDS staff 8/31/15 by ED.</li> <li>·In-service on IDT Admission/Readmission Review and Care PlanInitiation/Update conducted for IDT Team on 8/31/15 by ED.</li> <li>·ED/Designee will attend Clinical Meeting to ensure IDTAdmission/Readmission Review and Care Plan Update Process is followed.</li> </ul> <p><b>Howthe corrective action(s) will</b></p>	

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			<p><b>be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>·To ensure compliance, the DNS/Designee is responsible for the completion of the Admission/Readmission Procedure CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</li> <li>·To ensure compliance, MDS/Designee is responsible for the completion of the Temporary Admission Care Plan and the Care Plan Updating CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance.</li> <li>·ED/Designee will attend Clinical Meeting to ensure IDT Admission/Readmission Review and Care Plan Update Process is followed.</li> <li>·Attachments <ul style="list-style-type: none"> <li>·E, F, G, H, H1, H2, I, I1, J, J1, J2, J3, J4, K, L, M, N</li> </ul> </li> </ul>	

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F 0279 SS=D Bldg. 00	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview and record review, the facility failed to update care plans to reflect the discontinuation of a Foley catheter (Resident #B) and the insertion of a Foley catheter (Resident #E) for 2 of 4 residents reviewed for care plans.</p> <p>Findings include:</p> <p>1. The clinical record for Resident #B was reviewed on 8/12/15 at 1:00 p.m. Diagnosis included, but was not limited</p>	F 0279	<p>September 13, 2015</p> <p><b>F-279 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>·Resident's B and E did not have a negative outcome related to the alleged deficient practice.</li> <li>·Resident E's 6/6/15 significant change MDS was modified to add foley catheter on 8/27/15.</li> <li>·Resident E's foley catheter care plan was added on 8/13/15.</li> <li>·Resident B's care plan and MDS were updated /modified on 8/27/15. How other residents</li> </ul>	09/13/2015

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	<p>to, neurogenic bladder. The Minimum Data Set assessment, dated 7/25/15, indicated Resident #B's cognition was intact.</p> <p>During an observation on 8/12/15 at 1:30 p.m., Resident #B did not have an indwelling catheter. During an interview at the same time, Resident #B indicated he previously had a Foley catheter and it had been removed about a month ago.</p> <p>The nurses note, dated 7/18/15 at 6:54 p.m., included, but was not limited to, the following: "Patient was requesting F/C [Foley catheter] be pulled...F/C has been removed at this time..."</p> <p>The active care plan for Resident #B included, but was not limited to, the following: "...Problem Start Date: 07/12/2015...Resident requires an indwelling urinary catheter R/T [related to] Urinary Obstruction and Neurogenic Bladder d/t [due to] Morbid Obesity...."</p> <p>During an interview on 8/12/15 at 2:00 p.m., the DON (Director of Nursing) indicated Resident #B's Foley catheter was discontinued a couple of weeks ago.</p> <p>During an interview on 8/12/15 at 2:45 p.m., the Administrator indicated Resident #B's Foley catheter was</p>		<p>havingthe potential to be affected by the same deficient practice will be identifiedand what corrective action(s) will be taken?</p> <ul style="list-style-type: none"> <li>·All residents have the potential to be affected by the alleged deficientpractice.</li> <li>·Entire facility audit conducted 8/27/15 on MDSs coded for foley catheteron last MDS to ensure all are coded correctly and have corresponding careplans.</li> <li>·CQI catheter assessment tool completed 8/14/15 for all residents with acatheter to ensure consistency of care.</li> <li>·In-service on accurate foley catheter coding and care planning conductedfor MDS staff 8/27/15 by MDS Specialist.</li> <li>·In-service on Temporary Admission Care Plan and Care Plan Updatingconducted for MDS staff 8/31/15 by ED.</li> <li>·In-service on IDT Admission/Readmission Review and Care PlanInitiation/Update conducted for IDT Team on 8/31/15 by ED. What measures will be putinto place or what systemic changes will be made to ensure that the deficientpractice does not recur?</li> <li>·In-service on accurate foley catheter coding and care planning conductedfor MDS staff 8/27/15 by MDS Specialist.</li> <li>·In-service on Temporary Admission Care Plan and Care Plan Updatingconducted for MDS staff 8/31/15 by ED.</li> <li>·In-service on IDT</li> </ul>	

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	<p>discontinued on 7/18/15.</p> <p>2. The clinical record for Resident #E was reviewed on 8/13/15 at 11:00 a.m. Diagnosis included, but was not limited to, neurogenic bladder. The Minimum Data Set significant change assessment, dated 6/6/15, indicated Resident #E was incontinent of bladder.</p> <p>On 8/13/15, at 10:25 a.m., Resident #E was observed sitting on the side of the bed with a Foley catheter to bedside drainage in place.</p> <p>The physician order, dated 6/2/15, included, but was not limited to, the following: "...Order Description: Cath [catheter] orders: Foley catheter...Size 14fr [french] 10 ml [milliliters]...Diagnosis...Neurogenic bladder...."</p> <p>As of the date/time of record review, the clinical record for Resident #E lacked a comprehensive care plan for use of an Indwelling catheter.</p> <p>During an interview on 8/13/15 at 3:10 p.m., the DON (Director of Nursing) indicated Resident #E did not have a Foley catheter care plan in place. The DON also indicated Resident #E should have a Foley catheter care plan.</p>		<p>Admission/Readmission Review and Care PlanInitiation/Update conducted for IDT Team on 8/31/15 by ED.</p> <ul style="list-style-type: none"> <li>ED/Designee will attend Clinical Meeting to ensure IDTAdmission/Readmission Review and Care Plan Update Process is followed.</li> </ul> <p><b>Howthe corrective action(s) will be maintained to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>To ensure compliance, the DNS/Designee is responsible for the completionof the Admission/ReadmissionProcedur e CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthlytimes 6 and then quarterly until continued compliance is maintained for 2consecutive quarters. The results of these audits will be reviewed by the CQIcommittee overseen by the ED. Ifthreshold of 95% is not achieved an action plan will be developed to ensurecompliance.</li> <li>To ensure compliance, MDS/Designee is responsible for the completion of the Temporary Admission Care Plan and theCare Plan Updating CQI tool weekly times 4 weeks, bi-monthly times 2 months,monthly times 6 and then quarterly until continued compliance is maintained for2 consecutive quarters. The results ofthese audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not</li> </ul>	

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F 0323 SS=D Bldg. 00	<p>3.1-35(a) 3.1-35(c)(1) 3.1-35(d)(1)(2)(A)(B)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to determine the root cause analysis in order to determine effective interventions for 5 falls and failed to ensure fall interventions, according to the resident's plan of care, were in place to prevent an avoidable fall resulting a hematoma, for 1 of 3 residents reviewed for accidents. (Resident #C)</p> <p>Findings include:</p> <p>1. The closed record for Resident #C was reviewed on 8/12/15 at 1:50 p.m. Diagnoses included, but were not limited to, dementia, anxiety and urinary tract infection. The Minimum Data Set (MDS)</p>	F 0323	<p>achieved, an action plan will be developed to ensure compliance.</p> <ul style="list-style-type: none"> <li>ED/Designee will attend Clinical Meeting to ensure IDT Admission/Readmission Review and Care Plan Update Process is followed.</li> <li>Attachments <ul style="list-style-type: none"> <li>E, F, G, H, H1, H2, I, I1, J, J1, J2, J3, J4, K, L, M, N</li> <li>September 13, 2015</li> </ul> </li> </ul> <p>F-323 <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>Resident C no longer resides at the facility</li> </ul> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <ul style="list-style-type: none"> <li>All residents have the potential to be affected by the alleged deficient practice.</li> <li>Entire facility audit conducted 8/18/15 on all falls for the past 30 days to ensure the Fall Management Program was followed and a root cause</li> </ul>	09/13/2015

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	<p>assessment, dated 6/24/15, indicated Resident #C was an extensive, two person, physical assist with bed mobility and transfers and had a BIMS (Brief Interview of Mental Status) score of 6, which indicated impaired cognition.</p> <p>A Fall Event for Resident #C, dated 5/30/15 at 1:14 p.m., included, but was not limited to, the following: "...DESCRIPTION...Fall in pt [patient] room...Was fall witnessed...No...Describe what the resident was doing prior to the fall...trying to walk with walker...Describe the position of the resident when first observed after fall...sitting on floor...What intervention (s) was put into place to prevent another fall...walker removed from location, instructed pt [patient] to ask for help with transfers...."</p> <p>The IDT (Interdisciplinary Team) note, dated 6/1/15 at 10:51 a.m., included, but was not limited to, the following: "IDT met to review fall on 5/20/15 @ [at] 1:15 pm. Fall unwitnessed...Root cause: recent admission to facility, cognitive inability to know own self's limitations, decreased balance, [sic] weakness...."</p> <p>The Fall Event, dated 6/23/15 at 12:39 a.m., included, but was not limited to, the following: "DESCRIPTION...witness</p>		<p>analysis completed.</p> <ul style="list-style-type: none"> <li>·CQI Fall Management tool completed 8/18/15 to ensure consistency of care.</li> <li>·In-service on Fall Management Program completed for all nursing staff, IDT Team, and all new hire nursing staff by CEC/Designee by 9/13/15.</li> <li>·In-service on Temporary Admission Care Plan and Care Plan Updating conducted for MDS staff 8/31/15 by ED.</li> <li>·In-service on IDT Admission/Readmission Review and Care Plan Initiation/Update conducted for IDT Team on 8/31/15 by ED.</li> </ul> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> <li>·In-service on Fall Management Program completed for all nursing staff, IDT Team, and all new hire nursing staff on or before 9/11/15 by CEC/Designee</li> <li>·In-service on Temporary Admission Care Plan and Care Plan Updating conducted for MDS staff 8/31/15 by ED.</li> <li>·In-service on IDT Admission/Readmission Review and Care Plan Initiation/Update conducted for IDT Team on 8/31/15 by ED.</li> <li>·ED/Designee will attend Clinical Meeting to ensure Fall Management program is followed.</li> </ul> <p><b>How the corrective action(s) will</b></p>	

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	<p>fall...Describe what the resident was doing prior to the fall...slid out of her chair to the floor and scooting on the floor; urinary frequency...Describe the position of the resident when first observed after fall...upright sitting in front of her wheelchair [sic]...Was resident incontinent at time of fall...yes...What intervention (s) was put into place to prevent another fall...monitor for increased behaviors that will result in a fall in the near future...."</p> <p>The progress note, dated 6/23/15 at 12:44 a.m., included, but was not limited to, the following: "Per CNA [Certified Nursing Assistant] this patient was seen sliding out of her chair onto the floor and then scooting on the floor in the hallway. patient [sic] is with increased confusion; urinary frequency; [sic] denies pain at this time...."</p> <p>The IDT note, dated 6/23/15 at 2:24 p.m., included, but was not limited to, the following: "IDT met to review fall on 6/23/15 at 12:39 a.m. Fall was witnessed...Root cause: Confusion, residents [sic] cognitive inability to know own safety limitations, admission dx [diagnosis] of UTI [urinary tract infection], urinary frequency...."</p> <p>The Fall Event, dated 6/29/15 at 9:25</p>		<p><b>be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>·To ensure compliance, the DNS/Designee is responsible for the completion of the Fall Management CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</li> <li>·ED/Designee will attend Clinical Meeting to ensure IDT Admission/Readmission Review and Care Plan Update Process is followed.</li> <li>·Attachments</li> <li>·September 13, 2015</li> </ul>	

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	<p>a.m., included, but was not limited to, the following: "DESCRIPTION...Unwitnessed fall...Describe what the resident was doing prior to the fall...tring [sic] to get out of bed...Describe position of resident when first observed after fall...Patient was lying on the left side...environmental factors...poor lighting...What intervention (s) was put into place to prevent another fall...Put light on when patient is in bed, mattress infront [sic] of the bed...."</p> <p>The progress note, dated 4:15 a.m., included, but was not limited to, the following: "Resident was found by CNA lying on left side at bedside in bedroom...Resident stated she was trying to get out of bed...."</p> <p>The Fall Event, dated 6/30/15 at 9:45 p.m., included, but was not limited to, the following: "DESCRIPTION...fall...Describe what the resident was doing prior to the fall...out in hallway...Describe the position of the resident when first observed after fall...lying on side...What intervention (s) was put into place to prevent another fall...placed in bed and chair alarm added...."</p> <p>The progress note, dated 6/30/15 at 8:14 p.m., included, but was not limited to, the</p>			

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	<p>following: "trying [sic] to get into bed per self.brought [sic] resident back to med cart with this nurse to sit.resident [sic] then fell out of chair while trying again to get up...."</p> <p>The IDT note, dated 7/1/15 at 12:35 p.m., included, but was not limited to, the following: "IDT met to review fall on 6/30/15 at 8:15 pm. Fall was witnessed, prior to fall resident was trying to transfer self, nurse brought resident out to med cart, resident then attempted to ambulate from chair and began to fall and was lowered to the floor in hallway...Root cause identified as residents [sic] cognitive inability to known [sic] own safety limitations r/t [related to] dementia with behavioral disturbance...."</p> <p>The Fall Event, dated 7/6/15 at 9:03 a.m., included, but was not limited to, the following: "DESCRIPTION...Fall unwitnessed...Describe what the resident was doing prior to the fall...getting out of wheelchair [sic]...Describe the position of the resident when first observed after the fall...on floor by wheelchair [sic] in room...Was resident incontinent at time of fall...yes...What intervention (s) was put into place to prevent another fall...falls mat in place...."</p> <p>The progress note, dated 7/6/15 at 8:53</p>			

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	<p>a.m., included, but was not limited to, the following: "Resident found by CNA on floor...Opened a falls event patient very confused and educated on importance of using call light..."</p> <p>The IDT note, dated 7/7/15 at 11:32 a.m., included, but was not limited to, the following: "IDT met to review fall on 7/6/15 was unwitnessed...Root Cause/Contributing Factors: Inability to know own safety limitations d/t [due to] dx [diagnosis] of Dementia...Resident was incontinent at the time of the fall..."</p> <p>During an interview on 8/13/15 at 3:10 p.m., the DON (Director of Nursing) indicated the root cause of Resident #C's falls was the resident's inability to know her own safety limitations and dementia.</p> <p>On 8/14/15 at 9:30 a.m., the ADON (Assistant Director of Nursing) provided a copy of the document titled, "Fall Management Program", dated 2/2015. It included, but was not limited to, the following: "POLICY...It is the policy of [name of company] to ensure residents residing within the facility will maintain maximum physical functioning through the establishment of physical, environmental and psychosocial guidelines to prevent injury related to falls...PROCEDURE...Post fall...4. A fall</p>			

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	<p>event will be initiated...The report must be completed in full in order to identify possible root causes of the fall and provide immediate interventions. 5. All falls will be discussed by the interdisciplinary team at the 1st IDT meeting after the fall to determine root cause and other possible interventions to prevent future falls..."</p> <p>2. The closed record for Resident #C was reviewed on 8/12/15 at 1:50 p.m. Diagnoses included, but were not limited to, dementia, anxiety and urinary tract infection. The Minimum Data Set (MDS) assessment, dated 6/24/15, indicated Resident #C was an extensive, two person, physical assist with bed mobility and transfers.</p> <p>The Fall Event, dated 6/29/15 at 9:25 a.m., included, but was not limited to, the following: "DESCRIPTION...Unwitnessed fall...Describe what the resident was doing prior to the fall...tring [sic] to get out of bed...Describe position of resident when first observed after fall...Patient was lying on the left side...Describe resident appearance at time of fall...shoes off...Did the resident hit his/her head...yes...Describe injuries, if any, and the immediate treatment provided...Patient has hamatoma [sic] on</p>			

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	<p>the left side of the head...environmental factors...poor lighting...What intervention (s) was put into place to prevent another fall...Put light on when patient is in bed, mattress infront [sic] of the bed...."</p> <p>The progress note, dated 4:15 a.m., included, but was not limited to, the following: "Resident was found by CNA lying on left side at bedside in bedroom with gown on and no shoes or socks...Resident stated she was trying to get out of bed. Resident did hit her head, hematoma noted to the left side of forehead...."</p> <p>The Wound Skin Evaluation Form, dated 7/1/15 at 10:53 a.m., included, but was not limited to, the following: DESCRIPTION...hematoma to Left Side Forehead...Wound/skin condition type...Hematoma...Site...left side of forehead...Describe measurements in cm [centimeters]...9cm x [by] 7 cm x [by] 0...Describe wound color...purple...."</p> <p>The care plan for Resident #C included, but was not limited to, the following: "...Problem Start Date...6/1/2015...Resident is at risk for fall due to: history of falls, new admission, dementia, decreased mobility, attempts to transfer...Goal...Resident fall risk factors will be reduced in an attempt</p>			

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F 0514 SS=D Bldg. 00	<p>to avoid significant fall related injury...Approach Start Date: 6/1/2015...Non skid footwear...."</p> <p>During an interview on 8/13/15 at 3:13 p.m., the DON (Director of Nursing) clarified non skid footwear to be, non skid footwear at all times.</p> <p>On 8/14/15 at 9:30 a.m., the ADON (Assistant Director of Nursing) provided a copy of the document titled, "Fall Management Program", dated 2/2015. It included, but was not limited to, the following: "POLICY...It is the policy of [name of company] to ensure residents residing within the facility will maintain maximum physical functioning through the establishment of physical, environmental and psychosocial guidelines to prevent injury related to falls...."</p> <p>The Federal tag relates to the Investigation of Complaint IN00179607.</p> <p>3.1-45(a)(1)(2)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE</p>			

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	<p><b>SSIBLE</b></p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, interview and record review, the facility failed to discontinue a physician's order after the removal of a Foley catheter (Resident #B) and failed to ensure staff were documenting completed treatments in a timely manner (Resident #B) for 1 of 4 residents reviewed for medical records.</p> <p>Findings include:</p> <p>1. The clinical record for Resident #B was reviewed on 8/12/15 at 1:00 p.m. Diagnosis included, but was not limited to, neurogenic bladder.</p> <p>During an observation on 8/12/15 at 1:30 p.m., Resident #B did not have an indwelling catheter. During an interview at the same time, Resident #B indicated he previously had a Foley catheter and it had been removed about a month ago.</p>	F 0514	<p><b>F-514 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>· Resident B did not have a negative outcome related to the alleged deficient practice.</li> <li>· Resident B's care plan and MDS were updated /modified on 8/27/15. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</li> <li>· All residents have the potential to be affected by the alleged deficient practice.</li> <li>· Entire facility audit conducted 8/27/15 on MDSs coded for foley catheter on last MDS to ensure all are coded correctly and have corresponding care plans.</li> <li>· CQI catheter assessment tool completed 8/14/15 for all residents with a catheter to ensure consistency of care.</li> <li>· In-service on Med Pass with</li> </ul>	09/13/2015

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	<p>The nurses note, dated 7/18/15 at 6:54 p.m., included, but was not limited to, the following: "Patient was requesting F/C [Foley catheter] be pulled...F/C has been removed at this time..."</p> <p>The Treatments Administration History, between 7/19/15 and 7/31/15, included the following: "Cath [catheter] orders: Foley catheter care every shift...." The Treatments Administration History, between the same time frame, indicated Foley catheter care was provided 11/13 times on shift 7:00 a.m. - 3:00 p.m., 12/12 times on shift 3:00 p.m. -11:00 p.m., and 12/12 times on shift 11:00 p.m. - 7:00 a.m.</p> <p>The Treatments Administration History indicated the physicians order was discontinued on 7/31/15.</p> <p>During an interview on 8/12/15 at 2:45 p.m., the Administrator indicated Resident #B's Foley catheter was discontinued on 7/18/15.</p> <p>2. The clinical record for Resident #B was reviewed on 8/12/15 at 1:00 p.m. Diagnosis included, but was not limited to, neurogenic bladder.</p> <p>The physicians order, dated 7/30/15, included, but was not limited to, the</p>		<p>eMARand EHR policy conducted for all nursing staff and all newly hired nursingstaff by CEC/Designee by 9/13/15.</p> <ul style="list-style-type: none"> <li>·In-service on accurate foley catheter coding and care planning conductedfor MDS staff 8/27/15 by MDS Specialist.</li> <li>·In-service on Temporary Admission Care Plan and Care Plan Updatingconducted for MDS staff 8/31/15 by ED.</li> <li>·In-service on IDT Admission/Readmission Review and Care PlanInitiation/Update conducted for IDT Team on 8/31/15 by ED.</li> <li>·Facility audit conducted on all residents' treatment documentation toensure all documentation completed timely and by staff who performed thetreatment. What measures will be putinto place or what systemic changes will be made to ensure that the deficientpractice does not recur?</li> <li>·In-service on Med Pass with eMAR and EHR policy conducted for all nursingstaff and all newly hired nursing staff by CEC/Designee by 9/13/15.</li> <li>·In-service on accurate foley catheter coding and care planning conductedfor MDS staff 8/27/15 by MDS Specialist.</li> <li>·In-service on Temporary Admission Care Plan and Care Plan Updatingconducted for MDS staff 8/31/15 by ED.</li> <li>·In-service on IDT Admission/Readmission Review</li> </ul>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155697	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/14/2015
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NAME OF PROVIDER OR SUPPLIER  CLARK REHABILITATION AND SKILLED NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129
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	<p>following: "Silvadene [medication used to treat wounds] cream...topical...Special Instructions...Cleanse wound to abdominal fold with NS [normal saline], pat dry, apply silvadene cream, cover with ADB [dressing for wounds]...Scheduled Date...8/02/15...Charted Date - Time...8/12/15...12:50 p.m....Reasons/Comments...Late Administration: Charted late...Comment: 7-3 on 8/02/15...Created By...[DON [Director of Nursing] initials]...Scheduled Date...8/03/15...Charted Date - Time...8/12/15...12:51 p.m....Reasons/Comments...Late Administration: Charted late...Comment: Done 8/03/15 7am-3pm...Created By... [DON initials]...Scheduled Date...8/07/15...Charted Date - Time 8/12/15...12:57 p.m....Reasons/Comments...Late Administration: Charted late...Comment: completed on shift 7am-3pm...Created By...[DON initials]...Scheduled Date...8/10/15...Charted Date -Time...8/12/15...12:52 p.m....Reasons/Comments...Late Administration: Charted late...Comment: Completed on 8/10/15 at 1pm...Created By... [DON initials]...."</p> <p>During an interview on 8/13/15 at 3:45</p>		<p>and Care PlanInitiation/Update conducted for IDT Team on 8/31/15 by ED. ·ED/Designee will attend Clinical Meeting to ensure IDT Admission/ReadmissionReview and Care Plan Update Process is followed. ·Nurse Managers/Designee will review EMR compliance report each shift toensure physician and pharmacy notification is made per guidelines. <b>Howthe corrective action(s) will be maintained to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place?</b> ·To ensure compliance, the DNS/Designee is responsible for the completionof the Matrix Maintenance and Medical Records CQI tool weekly times 4 weeks,bi-monthly times 2 months, monthly times 6 and then quarterly until continuedcompliance is maintained for 2 consecutive quarters. The results of theseaudits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an actionplan will be developed to ensure compliance. ·To ensure compliance, MDS/Designee isresponsible for the completion of the Temporary Admission Care Plan and theCare Plan Updating CQI tool weekly times 4 weeks, bi-monthly times 2 months,monthly times 6 and then quarterly until continued</p>	

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NAME OF PROVIDER OR SUPPLIER  CLARK REHABILITATION AND SKILLED NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129
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	<p>p.m., the DON indicated she had printed off a compliance report and spoke with the nurse who worked on 8/2/15, 8/3/15, 8/7/15, and 8/10/15. The DON indicated the nurse told her she had completed the treatments and the DON signed the treatments out on the nurses behalf. The DON also indicated there was a 14 day window for staff to go back and sign out missed treatments.</p> <p>During an interview on 8/14/15 at 8:35 a.m., the Administrator indicated there was not a 14 day period or a policy for staff to go back and sign off missed treatments.</p> <p>This Federal tag relates to the Investigation of Complaint IN00179221.</p> <p>3.1-50(a)(2)</p>		<p>compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance.</p> <ul style="list-style-type: none"> <li>· ED/Designee will attend Clinical Meeting to ensure IDT Admission/Readmission Review and Care Plan Update Process is followed.</li> <li>· Nurse Managers/Designee will review EMR compliance report each shift to ensure physician and pharmacy notification is made per guidelines.</li> <li>· Attachments <ul style="list-style-type: none"> <li>· B, E, F, G, H, H1, H2, I, I1, J, J1, J2, J3, J4, K, M, N, S, T,</li> <li>· September 13, 2015</li> </ul> </li> </ul>	