

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155697	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/21/2013
--	---	--	---

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
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: May 14, 15, 16, 17, 18, 20 and 21, 2013</p> <p>Facility number: 000059 Provider number: 155697 AIM number: 100266560</p> <p>Survey team: Gloria J. Reisert MSW - TC Debbie Peyton, RN (5/20 and 5/21/13) Gwen Pumphrey, RN (5/14, 15, 16, 17, 20 and 21, 2 Census bed type: SNF: 3 SNF/NF: 64 Total: 67</p> <p>Census payor type: Medicare: 7 Medicaid: 47 Other: 13 Total: 67</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed by W. Christopher Greeney, QIDP</p>	F000000		
---------	---	---------	--	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155697	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/21/2013
--	---	--	---

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
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	5/29/2013.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155697		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/21/2013	
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			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to update the care plans when the resident's code status and discharge plans changed. This deficient practice affected 1 of 24 residents reviewed for care plans. (Resident #81)</p> <p>Finding included:</p> <p>Review of the clinical record for Resident #81 on 5/20/13 at 10:30 p.m. indicated the resident had diagnoses which included, but were not limited to Lung Cancer with metastasis to the brain and spine.</p>	F000280	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Residents have the right to participate in planning care and treatment or changes in care and treatment. Resident #81 is no longer a resident at the facility and did not have a negative outcome related to the alleged deficient practice. 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: All residents have the potential to be affected by the alleged deficient practice. SSD was re-educated on 6/5/13 by the</p>	06/05/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155697	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/21/2013
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		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Review of the care plans indicated the resident was originally admitted to facility on 2/22/13 for a 5 day respite stay but due to increasing confusion, agitation, inappropriate behaviors of urinating on floor and refusal of care and medications, the resident's responsible party decided to make this a permanent stay as she was not able to manage the resident care any longer.</p> <p>Review of the nursing documentation between 3/12 and 3/17/13 indicated the resident's overall condition began to deteriorate with increasing assist of all care needs. Because of this, the resident's responsible party and the resident chose to now make him a DNR [Do Not Resuscitate] instead of a full code - new form was signed on 5/12/13 to reflect the resident was a NO CODE.</p> <p>Review of the care plans dated 1/15/13 indicated the resident was still listed as being a full code [to be resuscitated] and being short term respite with plans to discharge home.</p> <p>During an interview with the RN Consultant on 5/21/13 at 1:46 p.m., she indicated each department was responsible for updating their own</p>		<p>DNSS on updating care plan problems, goals and interventions based on changes in resident assessment/condition, resident preference or family input relating to code status and discharge plans. 100% audit was completed on residents current code status and discharge plan 5/22/13 to ensure care plans are current and available to nursing staff by the SSD. Any resident found to not have a current care plan relating to code status/discharge plan was immediately updated by SSD/designee . <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b>SSD was re-educated on 6/5/13 by the DNSS on updating care plan problems, goals and interventions based on changes in resident assessment/condition, resident preference or family input relating to code status and discharge plans. 100% audit was completed on residents current code status and discharge plans 5/22/13 to ensure care plans are current and available to nursing staff by the SSD. Any resident found to not have a current care plan relating to code status/discharge plan was immediately updated by SSD/designee When a residents discharge plan or code status changes the Interdisciplinary team will monitor documentation</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155697	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/21/2013
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		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>care plans when changes occur.</p> <p>On 5/21/13 at 10:00 a.m., the Administrator presented a copy of the facility's current policy titled "Care Plan review and Maintenance Process". Review of this policy at this time included, but was not limited to: "...Procedure...Care plan problems, goals and interventions will be updated based on changes in resident assessment/condition, resident preferences or family input..."</p> <p>3.1-35(2)(d)(B)</p>		<p>in the residents chart to ensure code and discharge plans are updated. DNS/designee and SSD/designee are responsible to ensure compliance<b>How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b>To ensure compliance the SSD/designee is responsible for the completion of the advanced directive and social service care planning CQI tool weekly x 4, bi-monthly x 2 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of this audit 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>		