	F OF HEALTH AND HU R MEDICARE & MEDIO			FORM APPROVED OMB NO. 0938-0391			
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE		
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPI		
		155697	B. WING	00	04/29/2022		
			OTDEET	ADDRESS OFTW STATE ZID CODE	0.720		
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE			
CLARK F	REHABILITATION	AND SKILLED NURSING CENTE		LITTLE LEAGUE BLVD (SVILLE, IN 47129			
(X4) ID	SUMMADY	STATEMENT OF DEFICIENCIES	ID	, -		(¥5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE	
F 0000						DITL	
Bldg. 00							
J	This visit was for a	a Recertification and State	F 0000				
	Licensure Survey.	This visit included the					
		omplaint IN00372803.					
	G 11						
	-	2803 - Unsubstantiated due to					
	lack of evidence.						
	Survey dates: Apri	1 25, 26, 27, 28, and 29, 2022.					
	Facility number: 0	00059					
	Provider number:						
	AIM number: 1002						
	Census Bed Type:						
	SNF/NF: 68						
	Total: 68						
	Census Payor Type	2:					
	Medicare: 8						
	Medicaid: 46						
	Other: 14						
	Total: 68						
	There definitions	and and State Findings sited in					
	accordance with 4	reflect State Findings cited in					
	accordance with 4	10 IAC 10.2-5.1.					
	Quality review cor	npleted on May 9, 2022.					
F 0658	483.21(b)(3)(i)						
SS=E		d Meet Professional					
Bldg. 00	Standards						
		mprehensive Care Plans					
		vided or arranged by the					
	-	d by the comprehensive					
	care plan, must-						
		onal standards of quality.					
	Based on observati	ion, record review, and	F 0658	F658		05/29/2022	
	I) VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE		(X6) DATE	

(X6)

PRINTED: 06/01/2022

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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 X1) PROVIDER/SUPPLIER/CLL AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155697			(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 04/29/2022	
	PROVIDER OR SUPPLIER	AND SKILLED NURSING CENTE	R	517 N L	ADDRESS, CITY, STATE, ZIP CODE LITTLE LEAGUE BLVD SVILLE, IN 47129		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	interview, the facili	ty failed to ensure nursing			What corrective action(s) will be	•	
	services met profes	sional standards of care for			accomplished for those resident	ts	
	administration and	documentation of insulin and			found to have been affected by		
	blood glucose level	s, pressure ulcer			the deficient practice:		
	interventions, and c	hange of condition. This			Residents 24, 29, 33, and	k	
		ad the potential to affect all			36 are receiving blood glucose		
	68 residents residin	-			checks and insulin administratio	n	
					per physician orders.		
	Findings include:				Routine skin assessment	s	
	e				are documented accurately for		
	1. Standards of prac	ctice were not followed,			Resident 51.		
		cose level monitoring and			Resident 36 received		
	Ũ	sulin as ordered by the			appropriate interventions to		
		as 24, 36, 33, and 29 had			manage acute respiratory		
		of missing documentation of			symptoms, and is being monitor	red	
	-	ose levels and administration			for further respiratory symptoms		
	of insulin.	se levels and administration			How other residents having th		
	or msum.				potential to be affected by the	č	
	Cross Reference F6	SQ /			same deficient practice will be		
		eloped a facility acquired			identified and what corrective		
		assessments conducted by			action(s) will be taken:		
	-	naccurate, and the wound was			• All residents receiving		
	-	it had progressed to a stage 3.			blood glucose monitoring and		
	not identified until	it had progressed to a stage 5.			insulin administration, receive		
	Course Deference E(
	Cross Reference F6				routine skin monitoring, or have	a	
		experiencing changes in			change in condition have the		
		The clinical record lacked			potential to be affected by the		
		ppropriate monitoring,			alleged deficient practice.		
	assessment, and fol	low-up by nursing staff.			• An audit was completed b	by	
					DNS and IDT to identify all		
	Cross Reference F6	540			residents that receive blood		
	2.1.25(.)(1)				glucose monitoring and insulin		
	3.1-35(g)(1)				administration to ensure orders		
					have been followed.		
					• An audit was completed b	ру	
					DNS and IDT to identify all		
					residents with a change of		
					condition to ensure appropriate		
					follow up and MD notification ha	is	
					been completed.		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155697 B. WING 04/29/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 517 N LITTLE LEAGUE BLVD CLARK REHABILITATION AND SKILLED NURSING CENTER CLARKSVILLE, IN 47129 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG DEFICIENCY) All residents routine skin assessments were reviewed for accuracy by DNS and IDT. All nursing staff have been educated by DNS/designee on the Change of Condition Policy which includes appropriate follow up assessments and MD notification. All licensed nursing staff have been educated by DNS/designee on the Blood Glucose Monitoring Policy and Procedure which includes following physician orders and documentation. All nursing staff have been educated by DNS/designee on the Skin Management Program which includes accuracy of routine skin assessments. What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur: All nursing staff have been educated by DNS/designee on the Change of Condition Policy which includes appropriate follow up assessments and MD notification. All licensed nursing staff have been educated by DNS/designee on following Blood Glucose Monitoring Policy and Procedure which includes following physician orders and documentation. All nursing staff have been educated by DNS/designee on the Skin Management Program which

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Event ID:

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Facility ID: 000059

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AND PLAN OF CORRECTION IDE		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697	(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/29/2022		
	PROVIDER OR SUPPLIE	R AND SKILLED NURSING CENTE	517 N	ADDRESS, CITY, STATE, ZIP CODE LITTLE LEAGUE BLVD (SVILLE, IN 47129		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE DPRIATE	(X5) COMPLETI DATE
				 includes accuracy of routin assessments. Audit of all medical in of current residents will be completed daily by DNS/de to ensure any changes of condition receive appropria follow up assessment and notification of MD. Audit of all medical in of current residents will be completed daily by DNS/de to ensure blood glucose monitoring and insulin administration are docume all residents with these phy orders. Audit of all medical in of current residents will be completed daily by DNS/de to ensure blood glucose monitoring and insulin administration are docume all residents with these phy orders. Audit of all medical in of current residents will be completed daily by DNS/de to ensure to ensure that not skin assessments accurate identify all skin impairment How the corrective action will be monitored to ensure to ensure that not skin assessments accurate identify all skin impairment How the corrective action will be monitored to ensure to ensure that not skin assessments accurate identify all skin impairment How the corrective action will be monitored to ensure to ensure that not skin assessments accurate identify all skin impairment How the corrective action will be monitored to ensure to ensure that not skin assessments accurate identify all skin impairment How the corrective action will be monitored to ensure that not skin assessments accurate identify all skin impairment How the corrective action will be monitored to ensure that not skin assessments accurate identify all skin impairment How the corrective action will be monitored to ensure that not skin assessments accurate identify all skin impairment How the corrective action will be monitored to ensure that not skin assessments accurate identify all skin impairment How the corrective action will be developed to ensure that not skin assessments accurate identify all skin impairment How the corrective action will be developed to ensure that not skin assessments accurate identify and the skin assessments accurate identify	records esignee ate records esignee ented for ysician records esignee outine ely t. n(s) ire the t te te te y for 8 ths and he be nmittee eshold a action	

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number: 155697	ì í	ILDING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/29/2022	
	PROVIDER OR SUPPLIE	R R AND SKILLED NURSING CENTE	ER	517 N I	ADDRESS, CITY, STATE, ZIP CODE LITTLE LEAGUE BLVD SVILLE, IN 47129		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
					Attachments: A, B, C, D, E, F May 29, 2022	, G	
F 0684 SS=E Bldg. 00	applies to all trea facility residents. comprehensive a facility must ensu- treatment and ca professional stan	a fundamental principle that tment and care provided to Based on the ssessment of a resident, the re that residents receive re in accordance with dards of practice, the erson-centered care plan,					
	facility failed to en and blood glucose documented as ord	view and interview, the sure insulin was administered levels were obtained and ered by the physician for 4 of yed for Quality of Care. 3, and 36)	F 06	84	F684 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: • Residents 24, 29, 33, an	ı nd	05/29/2022
	reviewed on 4/29/2 included, but were mellitus with hype	to diabetes mellitus, and			36 are receiving blood glucose checks and insulin administrat per physician orders. How other residents having t potential to be affected by th same deficient practice will b identified and what corrective action(s) will be taken:	ion :he e oe	
	assessment, dated a was cognitively int	S (Minimum Data Set) 3/1/22, indicated the resident act and received insulin.			All residents receiving blood glucose monitoring and insulin administration, have the potential to be affected by the	e	
	resident was at risk hyperglycemia or l	d 11/6/19, indicated the for adverse effects of hypoglycemia related to use of hedication and/or diagnoses of			alleged deficient practice. • An audit was completed DNS and IDT to identify all residents that receive blood	l by	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY

FORM APPROVED OMB NO. 0938-0391

PRINTED: 06/01/2022

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155697	A. BUILDING B. WING	00	COMPLET: 04/29/20	
NAME OF	PROVIDER OR SUPPLIEF		STREET	ADDRESS, CITY, STATE, ZIP COI	DE	
			517 N I	LITTLE LEAGUE BLVD		
CLARK	REHABILITATION A	ND SKILLED NURSING CENTE	ER CLARK	(SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	ULD BE C	OMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	ROPRIATE	DATE
	diabetes mellitus ty	pe 1. The interventions		glucose monitoring and i	nsulin	
		not limited to, document		administration to ensure		
	abnormal findings a	and notify MD (Medical		have been followed.		
	Doctor), laboratory	tests as ordered, medications		· All licensed nursin	g staff	
	as ordered, monitor	blood sugars as ordered, and		have been educated by	-	
	observe for symptom	ms of hyperglycemia and		DNS/designee on followi	ing Blood	
	hypoglycemia.			Glucose Monitoring Polic	cy and	
				Procedure which include	s	
	The physician's ord	er, dated 1/3/22, indicated		following physician order	rs and	
	staff were to admin	ister 20 units of Basaglar		documentation.		
	KwikPen insulin tw	vice daily at 6:30 a.m. and		What measures will be	put into	
	8:00 p.m.			place and what systemi	ic	
				changes will be made to	o ensure	
	The physician's ord	er, dated 7/12/21, indicated to		that the alleged deficier	nt	
	administer insulin l	ispro three times daily at		practice does not recur	:	
	6:30 a.m., 11:30 a.r	n., and 4:30 p.m., per sliding		All licensed nursin	g staff	
	scale as follows:			have been educated by		
	-	less than 60, call MD.		DNS/designee on followi		
	-	0 to 199, give 0 units.		Glucose Monitoring Polic	cy and	
	-	200 to 250, give 3 units.		Procedure which include		
	-	251 to 300, give 6 units.		following physician order	rs and	
	-	301 to 350, give 9 units.		documentation.		
	-	351 to 400, give 12 units.		Audit of all medica		
	-	greater than 400, give 15		of current residents will b		
	units.			completed daily by DNS/	/designee	
	If blood sugar was	greater than 400, call MD.		to ensure blood glucose		
				monitoring and insulin		
		er, dated 11/4/19, indicated to		administration are docun		
		cose level check as needed		all residents with these p	ohysician	
		ms of hypoglycemia or		orders.		
	hyperglycemia.			How the corrective action		
	The second Col. 1	(AD (Madiantian		will be monitored to ens		
	The review of the N	-		deficient practice will ne	σι	
		ord) for January 2022		recur: QA	loto the	
	indicated the follow	/ing:		DNS/designee will comp		
	The ender f ' 1'	n lianna alidin1-1, 1, 1, 1		Diabetic Monitoring QA t		
		n lispro sliding scale lacked		weekly for 8 weeks, mon		
		lood glucose levels and		months and quarterly for		
		iding scale insulin on January		quarters. The results of		
	1 at 11:30 a.m., Jan	uary 2 at 11:30 a.m., January		will be reviewed by the C	JAPI	

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Event ID:

2HG111

Facility ID: 000059

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DEPARTMENT	OF HEALTH AND HUMAN SERVICES	
CENTERS FOR	MEDICARE & MEDICAID SERVICES	

STATEMENT OF DI AND PLAN OF COR		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697	r /	ILDING	NSTRUCTION 00	CO	ate survey mpleted /29/2022
NAME OF PROVIDE		ND SKILLED NURSING CEN	TER	517 N LI	ddress, city, state, zip c TTLE LEAGUE BLVD SVILLE, IN 47129	CODE	
	EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE . DEFICIENCY)	RRECTION HOULD BE APPROPRIATE	(X5) COMPLETIC DATE
5 and Janua and 1 The c daily insuli 6 at 6 21 at 6:30 29 at On Ja gluco (milli units	6 at 6:30 a.m. rry 21 at 6:30 a 1:30 a.m., and order for Basag lacked docume n or blood glue :30 a.m., Januar both 6:30 a.m. a.m., January 2 6:30 a.m. unuary 3 at 6:30 grams per deci of sliding scale	January 8 at 11:30 a.m., .m., January 26 at 6:30 a.m. January 29 at 6:30 a.m. lar KwikPen 20 units twice entation of administration of cose levels on January 5 and ry 19 at 8:00 p.m., January and 8:00 p.m., January 26 at 7 at 8:00 p.m., and January 0 a.m., the resident's blood ocumented as 488 mg/dl liter) and he required 15			Committee overseen k If threshold of 95% is r achieved, an action pla developed to ensure c Attachments: B, D, G May 29, 2022	not an will be	DATE
The o docur admin Febru The r	mentation of bl nistration of sli uary 19, 24, and	n lispro sliding scale lacked ood glucose levels and ding scale insulin on 1 26 at 6:30 a.m. IAR for March 2022					
docur admir 3, at at 6:3 both	nentation of bl nistration of sli 5:30 a.m., Mar 0 a.m., March	n lispro sliding scale lacked ood glucose levels and ding scale insulin on March ch 5 at 11:30 a.m., March 6 8 at 6:30 a.m., March 12 at 1:30 a.m., March 17 at 4:30 at 4:30 p.m.					
daily insuli	lacked docume n or blood glue	lar KwikPen 20 units twice entation of administration of cose levels on March 1 at at 6:30 a.m., March 6 at 6:30					

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			STRUCTION	î î	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI B. WING		00		APLETED
		155697	B. WING	·		04/2	29/2022
NAME OF	PROVIDER OR SUPPLIEI	3	S	STREET AL	DDRESS, CITY, STATE, ZIP COE	DE	
					TTLE LEAGUE BLVD		
CLARK	REHABILITATION A	AND SKILLED NURSING CENT	ER	LARKS	VILLE, IN 47129		
X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	D	PROVIDER'S PLAN OF CORREC	CTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	LD BE	COMPLET
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)	1	TAG	DEFICIENCY)		DATE
		30 a.m., March 12 at 6:30					
		:00 p.m., and March 31 at					
	8:00 p.m.						
	On March 8 at 11.3	0 a.m., the resident's blood					
	glucose level was 5						
	-	le insulin lispro and an					
	additional 10 units	-					
	-	8					
	The review of the M	MAR for April 2022 indicated					
	the following:						
		in lispro sliding scale lacked					
		lood glucose levels and					
		liding scale insulin on April 6					
	11:30 a.m., and Ap	15 at 6:30 a.m., April 16 at					
		111 25 at 0.50 a.m.					
	The order for Basa	glar KwikPen 20 units twice					
		entation of administration of					
	insulin or blood glu	cose levels on April 6 at 6:30					
	a.m., April 8 at 8:0	0 p.m., April 15 at 6:30 a.m.,					
	-	n., April 26 at 8:00 p.m., and					
	April 28 at 8:00 p.r	n.					
	During on interview	$x = \frac{1}{20}$					
	-	v, on 4/29/22 at 10:43 a.m., ctical Nurse) 8 indicated					
		ed insulin. They monitored his					
		s and had parameters to					
		n of any blood glucose levels					
		below 60 mg/dl. He was on					
	sliding scale insulin						
		s sliding scale orders as					
	required.						
		v, on 4/29/22 at 2:31 p.m., the					
		g (DON) indicated if the MAR					
	_	indicated missed medication					
		ot administering insulin would cose level to raise. There					
	cause the blobu glu			1			

		NAL DROUNDER (AVERALIES)	Law		I	OMB NO. 0938-03 (X3) DATE SURVEY	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	. ,		NSTRUCTION		
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00		MPLETED
		155697	B. W	ING		04,	/29/2022
NAME OF	PROVIDER OR SUPPLIE	{	_	STREET A	CODE		
		AND SKILLED NURSING CENT	TED		ITTLE LEAGUE BLVD SVILLE, IN 47129		
					5VILLE, IN 47 129		
X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE		COMPLET
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	should not be any h						
		rd for Resident 36 was					
		2 at 1:15 p.m. The diagnoses					
		not limited to, diabetes					
		tic chronic kidney disease					
		ase, stage 5, end stage renal					
		akness, coronary artery					
		sleep apnea, chronic					
		e) heart failure, hypertension,					
		brillation, acute and chronic					
	respiratory failure v	with hypercapnia.					
	The Quarterly MDS	S assessment, dated 12/17/21,					
		nt was cognitively intact.					
		2					
	The care plan, date	d 7/16/21 and last revised					
	3/22/22, indicated t	he resident was at risk for					
	adverse effects of h	yperglycemia or					
	hypoglycemia relat	ed to use of glucose lowering					
	medication and/or o	liagnosis of diabetes mellitus.					
	The interventions in	ncluded, but were not limited					
		d Humalog QID (four times a					
	day) and Lantus q I	HS (bedtime), diet as ordered,					
		d offer replacements for 50%					
	or less consumption	n, document abnormal					
		the physician, laboratory tests					
		tions as ordered, monitor					
		ered and observe for					
		glycemia: such as sweating,					
		, pallor nervousness,					
		speech, lack of coordination,					
	and staggering gait.						
	The physician's ord	ers included the following:					
		sulin (insulin lispro)					
		nL per sliding scale;					
	If blood sugar is les						
	If blood sugar is 0 t						
	-	0 to 250, give 11 units.					
	-	1 to 300, give 13 units.					
	11 01000 Bugur 10 20						

0.000			ATA: 1 /	TIN S OF		OMB NO. 0938-03 (X3) DATE SURVEY		
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ISTRUCTION	. ,		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI		00		PLETED	
		155697	B. WIN	G		04/29/202		
NAME OF	PROVIDER OR SUPPLIEI	R		STREET ADDRESS, CITY, STATE, ZIP CODE				
					TTLE LEAGUE BLVD			
CLARK	REHABILITATION A	AND SKILLED NURSING CENT	ER	CLARKS	SVILLE, IN 47129			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC	TION	(X5)	
PREFIX	(EACH DEFICIEN	VCY MUST BE PRECEDED BY FULL	Р	REFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	JLD BE	COMPLET	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	If blood sugar is 30	01 to 350, give 15 units.						
	-	51 to 400, give 17 units.						
		eater than 400, give 20 units.						
	If blood sugar is gr							
	Subcutaneous, four							
	of 3/7/22.							
	Insulin glargine ins	ulin pen; 100 unit/mL (3 mL)						
		cous at bedtime with a start						
	date of $4/26/22$.	ous at ocatime with a start						
	Insulin glargine ins	sulin pen 100 units/ml 55 units						
		times a day with a start date of						
	12/13/21 and disco	ntinue date 2/25/22.						
	Humalog II-100 In	sulin 100 units/ml 7 units						
	-							
	subcutaneous, three times a day was restarted on $3/7/22$.							
		lacked documentation						
		ent's blood sugars and insulin						
	were given as order	red on the following dates:						
	Humalog 7 units th	ree times a day was not given						
	on:	, ,						
	1/5/22 at 6:30 a.m.							
	1/7/22 at 11:30 a.m	1.						
	1/15/22 at 11:30 a.m	m.						
	1/21/22 at 6:30 a.m	1.						
	1/22/22 at 11:30 a.m	m.						
	1/26/22 at 6:30 a.m	1.						
	1/29/22 at 11:30 a.	m.						
	1/30/22 at 11:30 a.	m. and 4:30 p.m.						
	3/8/22 at 6:30 a.m.							
	3/27/22 at 11:30 a.	m.						
	4/8/22 at 4:30 p.m.							
	4/10/22 at 11:30 a.	m.						
	4/11/22 at 11:30 a.							
	4/15/22 at 11:30 a.	m. and 4:30 p.m.						
	4/18/22 at 4:30 p.m	1.						

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697	(X2) MULTIP A. BUILDIN B. WING	NG	00	(X3) DATE SURVEY COMPLETED 04/29/2022	
	PROVIDER OR SUPPLIEF	AND SKILLED NURSING CENTE	51	7 N LIT	DRESS, CITY, STATE, ZIP CODE TLE LEAGUE BLVD /ILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES					(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F		COMPLETIO
TAG		LSC IDENTIFYING INFORMATION)	TA		CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
	4/19/22 at 4:30 p.m	l.					
	4/23/22 at 11:30 a.1						
	4/25/22 at 4:30 p.m	-					
	Lantus insulin 55 u	nits subcutaneous at bedtime					
	was not given on						
	1/7/22 at 8:00 p.m.						
	1/17/22 at 8:00 p.m	I.					
	1/21/22 at 8:00 p.m	I.					
	2/4/22 at 8:00 p.m.						
	Humalog administe	er per sliding scale was not					
	given on:						
	1/5/22 at 6:30 a.m.						
		. The resident blood sugar at					
		mg/dl. An order from the					
		to recheck the blood sugar in					
	1 hours. The clinica						
		blood sugar was taken.					
	1/10/22 at 8:00 p.m						
	1/11/22 at 8:00 p.m 1/12/22 at 8:00 p.m						
	1/12/22 at 8:00 p.m 1/12/22 at 6:30 a.m						
	1/17/22 at 0.50 a.m						
	1/21/22 at 6:30 a.m						
	1/22/22 at 11:30 a.t						
	1/29/22 at 11:30 a.1	n.					
	1/31/22 at 11:30 a.1	m. and 4:30 p.m.					
	2/2/22 at 11:30 a.m	- I.					
	2/4/22 at 11:30 a.m	L.					
	2/4/22 at 11:30 a.m	L.					
	2/5/22 at 11:30 a.m	l.					
	2/6/22 at 11:30 a.m	l.					
	2/7/22 at 11:30 a.m						
	2/8/22 at 4:30 p.m.	and 8:00 p.m.					
	3/8/22 at 6:30 a.m.						
	3/9/22 at 8:00 a.m.						
	3/12/22 at 11:30 a.1						
	3/15/22 at 8:00 a.m						
	3/18/22 at 8:00 p.m	l.					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697	A. BUILDI B. WING		C0	(X3) DATE SURVEY COMPLETED 04/29/2022	
	PROVIDER OR SUPPLIEF	ND SKILLED NURSING CENT	51	REET ADDRESS, CITY, S 7 N LITTLE LEAGU ARKSVILLE, IN 47	JE BLVD		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREF	PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO T		COMPLETI	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TA		DEFICIENCY)	DATE	
	LPN 8 indicated the before giving insuli amount would be d would still chart in give insulin. Each s filled in and not lef indicates the blood insulin was not give 3. The clinical reco reviewed on 4/27/2	 . and 8:00 p.m. n. and 8:00 p.m. n. n. d 4:30 p.m. d 4:30 p.m. and 4:30 p.m. and 8:00 p.m. and 8:00 p.m. <i>x</i>, on 4/29/22 at 1:39 p.m., e resident's blood sugar n. The blood sugar and insulin ocumented in the MAR. You the MAR even if you did not quare on the MAR should be to blank. If left blank that sugar was not taken and the en. rd for Resident 33 was 2 at 1:58 p.m. The diagnoses 					
	mellitus, alcohol-in dementia with beha schizoaffective disc	not limited to, type 2 diabetes duced chronic pancreatitis, vioral disturbance, order, vitamin D deficiency, pathic neuropathy, cognitive					
	indicated the reside impaired. The care plan, date 3/22/22, indicated t	S assessment, dated 3/16/22, nt was severely cognitively d 7/13/16 and revised on he resident was at risk for					
	adverse effects of h hypoglycemia relat	yperglycemia or ed to the use of glucose					

TATEM	NT OF DEFICIENCIES		WALL DE		ISTRUCTION	TVAL D +	TE CUDATES	
	NT OF DEFICIENCIES					. ,	(X3) DATE SURVEY COMPLETED	
ND PLAN	OF CORRECTION				00			
		155697	B. WIN	IG		- 04/2	29/2022	
NAME OF	PROVIDER OR SUPPLIEI	2			DDRESS, CITY, STATE, ZIP CO	DDE		
JLARK	REHABILITATION A	AND SKILLED NURSING CENT	IER	CLARKS	SVILLE, IN 47129			
X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)	
PREFIX	,	ICY MUST BE PRECEDED BY FULL	I	REFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF		COMPLET	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	-	n and a diagnosis of diabetes						
		ventions, dated 7/13/16,						
		ent abnormal findings and						
		nitor blood sugars as ordered.						
		oms of hyperglycemia or						
	hypoglycemia.							
	The physician's ord	ers included, but were not						
	limited to the follow							
	Insulin lispro insuli	n pen; 100 unit/mL; amount:						
	-	blood sugar was less than 60,						
		ugar was 61 to 149, give 0						
		r was 150 to 199, give 3 units.						
	-	200 to 249, give 6 units. If						
	-	blood sugar was 250 to 299, give 8 units. If						
	-	0 to 349, give 11 units. If						
	-	0 to 400, give 13 units. If						
	-	eater than 400, give 13 units.						
		greater than 400, call MD.						
	-	ir times a day 6:00 a.m.,						
	starting 1/28/20 and	d restarted on 1/10/21 and						
	7/25/21, open ende	d.						
	Accucheck as need	ed for signs or symptoms of						
	hyper or hypoglyce	mia. Notify MD if blood						
	sugar was less than	60 or greater than 400 as						
	needed, starting 1/2	28/20.						
	The MAR lacked d	ocumentation of blood sugar						
		n administration on the						
	following dates and	times:						
	4/29/21 no reading	at 8:00 p.m.						
	5/4/21 no reading a							
	7/1/21 no reading a	-						
	7/8/21 no reading a	-						
	8/5/21 no reading a							
	8/26/21 no reading							
	9/2/21 no reading a							

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING CEREET ADDRESS, CIEV. STATE 710 CODI		COM	(X3) DATE SURVEY COMPLETED 04/29/2022	
NAME OF	PROVIDER OR SUPPLIEI	ξ			DDRESS, CITY, STATE, ZIP CODI	Ξ		
CLARK	REHABILITATION A	AND SKILLED NURSING CENT	ER		TTLE LEAGUE BLVD WILLE, IN 47129			
X4) ID SUMMAR		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT	YON	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE	COMPLETI	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	OTTAKTE	DATE	
	9/7/21 no reading a	t 8:00 p.m.						
	9/16/21 no reading	at 8:00 p.m.						
	9/22/21 no reading	at 8:00 p.m.						
	10/3/21 no reading	at 6:00 a.m.						
	10/5/21 no reading	at 8:00 p.m.						
	10/14/21 no reading	g at 6:00 a.m. or 8:00 p.m.						
	11/2/21 no reading	at 8:00 p.m.						
	11/4/21 no reading	at 8:00 p.m.						
	8/9/21 no reading a	t 8:00 p.m.						
	11/16/21 no reading							
	11/23/21 no reading	-						
	11/24/21 no reading	g at 8:00 p.m.						
	12/3/21 no reading	at 8:00 p.m.						
	12/6/21 no reading	at 4:30 p.m.						
	12/11/21 no reading	g at 11:30 a.m., or 8:00 p.m.						
	12/12/21 no reading							
	12/15/21 no reading							
	12/25/21 no reading							
	12/30/21 no reading							
	1/1/22 no reading a							
	1/2/22 no reading a							
	1/6/22 no reading a	-						
	1/8/22 no reading a							
	1/19/22 no reading							
	1/21/22 no reading	-						
	-	at 6:00 a.m. or 11:30 a.m.						
	2/5/22 no reading a	-						
	2/15/22 no reading							
		at 4:30 p.m. or 8:00 p.m.						
	4/16/22 no reading							
	4/20/22 no reading							
	4/21/22 no reading							
	4/24/22 no reading							
		at 6:00 a.m. or 8:00 p.m.						
	4/26/22 no reading							
	4/28/22 no reading	at 8:00 p.m.						
		v, on 4/29/22 at 10:05 a.m.,						
		e resident's blood sugars ran						
	in the high 300s us	ually. She documented the						

DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

FORM APPROVED

TATEME	NT OF DEFICIENCIES	CAID SERVICES X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION		OMB NO. 0938-039 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		. ,	IE SORVEI IPLETED
IND FLAN	OF CORRECTION	155697	B. WING	00		29/2022
		133097				29/2022
NAME OF 1	PROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZI		
				LITTLE LEAGUE BLVI	2	
CLARK I	REHABILITATION A	AND SKILLED NURSING CENT	ER CLARK	SVILLE, IN 47129		
X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF O	CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	N SHOULD BE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY		DATE
	U U	MAR. A box would pop up in				
	the medication area	a, for the blood sugar readings.				
	4 The clinical reco	ord for Resident 29 was				
		2 at 1:03 p.m. The diagnoses				
		not limited to, type 2 diabetes				
		llcer, diabetic neuropathy, and				
	diabetic (poly) neu					
	diabetic (pory) neu	Topaniy.				
	The Quarterly MD	S assessment, dated 3/4/22,				
	indicated the reside	ent was cognitively intact.				
	The care plan, date	d 9/10/21, indicated the				
	· ·	for adverse effects of				
	hyperglycemia or h	hypoglycemia related to the				
		ering medication and/or				
	-	es mellitus. The interventions				
	-	not limited to, document				
		and notify MD, laboratory				
	tests as ordered, me	edications as ordered, and				
	monitor blood suga	ars as ordered.				
	The physician's ord	lers included, but were not				
	limited to the follow					
		lin pen; 100 unit/mL; amount:				
		blood sugar was less than 60,				
		ugar was 61 to 149, give 0				
		r was 150 to 199, give 3 units.				
	-	200 to 249, give 6 units. If				
	-	50 to 299, give 8 units. If				
		00 to 349, give 11 units. If				
	blood sugar was 35	50 to 400, give 13 units. If				
		eater than 400, give 13 units.				
		greater than 400, call MD.				
		ır times a day 6:00 a.m.,				
	starting 2/17/22 and	d was open ended.				
	Accucheck as need	ed for signs or symptoms of				
		emia. Notify the MD if blood				
	JI JF-8-J	,				

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPLE CON	NSTRUCTION	(Y3) D 4 7	OMB NO. 0938-0 (X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII			COMPLETED		
AND PLAN			A. BUII B. WIN		00	•		
		155697					9/2022	
NAME OF	PROVIDER OR SUPPLIEI	3			DDRESS, CITY, STATE, ZIP COI	DE		
LARK	REHABILITATION	AND SKILLED NURSING CENT	ER	CLARKS	SVILLE, IN 47129			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC	CTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	ULD BE	COMPLET	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	-	60 or greater than 400 as						
	needed, starting 9/2	22/21 and was open ended.						
	The MAP locked d	ocumentation of blood sugar						
		n administration on the						
	following dates and							
	-	t 6:00 a.m.,12:00 p.m. and						
	8:00 p.m.	. 0.00 u.m.,12.00 p.m. und						
	3/7/22 no reading a	t 8:00 p.m.						
	-	t 6:00 a.m. and 8:00 p.m.						
	-	at 4:00 p.m. and 8:00 p.m.						
	-	at 12:00 p.m. and 8:00 p.m.						
		at 6:00 a.m. and 8:00 p.m.						
	3/21/22 no reading	at 12:00 p.m.						
	3/22/22 no reading	at 12:00 p.m. and 4:00 p.m.						
	3/24/22 no reading	at 4:00 p.m.						
	3/26/22 no reading	at 4:00 p.m.						
	3/30/22 no reading	-						
		t 12:00 p.m. and 8:00 p.m.						
	4/7/22 no reading a	-						
	4/8/22 no reading a							
	4/10/22 no reading							
	4/11/22 no reading	-						
	4/12/22 no reading							
	4/15/22 no reading	-						
	4/17/22 no reading 4/18/22 no reading	-						
		at 4:00 p.m. and 8:00 p.m.						
	4/23/22 no reading 4/23/22 no reading							
		at 4.00 p.m.						
	The Blood Glucose	Monitoring policy, dated						
		s provided by the DON on						
	-	m. The policy included, but						
		" Residents who have a						
	physician's order to	obtain routine capillary						
	blood glucose will	have a physician's order						
	specifying the bloo	d glucose parameters						
	requiring physician	notification The physician						
	will be notified wh	en the resident's blood						
	glucose is outside t	he physician stated						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697	(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/29/2022	
	PROVIDER OR SUPPLIE	R AND SKILLED NURSING CENTI	T ADDRESS, CITY, STATE, ZIP CODE I LITTLE LEAGUE BLVD KSVILLE, IN 47129			
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) e resident is experiencing	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
= 0686 SS=D Bldg. 00	signs or symptoms Blood glucose rest Capillary Blood G the medication adr 3.1-37(a) 483.25(b)(1)(i)(ii) Treatment/Svcs f Ulcer §483.25(b) Skin I §483.25(b) Skin I §483.25(b)(1) Pro Based on the cor a resident, the fa (i) A resident reco professional stan pressure ulcers a pressure ulcers a prevent new ulce Based on, observar interview, the facili interview, the facili interventions and a to prevent the devo pressure ulcers, wild evelopment of a s residents right butt Findings include:	of high or low blood sugar alts will be documented on the blucose Monitoring Tool or on ministration record." o Prevent/Heal Pressure ntegrity essure ulcers. mprehensive assessment of cility must ensure that- eives care, consistent with dards of practice, to prevent and does not develop mless the individual's clinical strates that they were h pressure ulcers receives sent and services, consistent standards of practice, to prevent infection and rs from developing. cion, record review, and ity failed to ensure assessments were implemented elopment or worsening of new 1 of 4 residents reviewed for nich resulted in the stage III pressure ulcers to the	F 0686	F686 What corrective action(s) w be accomplished for those residents found to have bee affected by the deficient practice: • Residents #51 is provide preventive treatments/measure based on identified risks to prevent further skin breakdow and accuracy of routine skin	e n ded ires	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE COMPI 04/29	LETED
NAME OF PROVIDER OR SUPPLI	AND SKILLED NURSING CENT	517 N	TADDRESS, CITY, STATE, ZIP (LITTLE LEAGUE BLVD KSVILLE, IN 47129	CODE	
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
TAGREGULATORY Oright buttocks with dry. She applied S packed the wound saline. She applie a dressing. The wo of a quarter. Gram with no drainage o wound bed. The w indicated the woundThe clinical record on 3/27/22 at 10:4 included, but were malnutrition, must of coordination, d obstructive pulmoThe Quarterly MI assessment, dated was severely cogr extensive assistan assistance with dr and supervision wThe care plan, datt resident was at riss Pressure ulcer to t interventions inclu assess for pain, tro of unrelieved or w weekly, document description, turn a encourage the resi (percent) of meals	R LSC IDENTIFYING INFORMATION) a normal saline and patted it antyl to the open wound and with gauze soaked in normal d optifoam and covered it with bund was approximately the size ulation tissue (healthy tissue) or no foul odor covered the yound NP (Nurse Practitioner) and continued to tunnel. d for Resident 51 was reviewed 9 p.m. The diagnoses e not limited to, dementia, cle weakness, unspecified lack ysphagia, and chronic nary disease, DS (Minimum Data Set) 3/25/22, indicated the resident itively impaired. She required ce for bed mobility, extensive essing and personal hygiene,	TAG	CROSS-REFERENCED TO THE DEFICIENCY How other residents potential to be affects same deficient practic identified and what c action(s) will be take · All residents have t to be affected by the a deficient practice. · All residents with po develop pressure wou IDT review of orders a plans for preventative for pressure ulcers. · Skin assessments of completed by DNS/des Skin Management Pro- which includes the use preventative measure pressure ulcer develop accuracy of routine sk assessments What measures will to place and what syste changes will be made that the deficient pra- not recur: · All nursing staff educated by DNS/des Skin Management Pro-	having the ed by the ice will be corrective n: the potential alleged otential to unds will have and care measures will be esignees to cent routine nsure I be signee on ogram Policy e of es for pment and cin	DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697	(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/29/2022	
	NAME OF PROVIDER OR SUPPLIER CLARK REHABILITATION AND SKILLED NURSING CENTE			ADDRESS, CITY, STATE, ZIP CODI LITTLE LEAGUE BLVD KSVILLE, IN 47129	3	
CLARK I PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY O The Weekly Skin dated 10/27/21 and resident's skin was non-tenting and no documented. The IDT notes, da suspected deep tisi injury to the right was a stage III. The Wound Mana indicated the resid wound to the right (centimeters) in a 1 width from side to could not be meas was covered by 75 yellowish slough. dark purple or rust erythema was blar clear, amber in col The physician's or wound NP (Nurse treat, low air matta and weekly skin as The physician's or discontinued on 12	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) and Vital Signs Assessment, d 11/5/21 indicated the s warm, dry and pink, o edema. No open areas were ted 11/1/21, indicated a sue. A new wound with skin buttock. The pressure wound gement Report, dated 11/1/21, ent had a stage III pressure buttock. The length was 3cm head-to-toe direction. The o side was 2.5 cm and the depth ured at that time. The wound is% granulation tissue and 25% The surrounding tissue was ty discoloration, and the nethable. Serous drainage was lor and the thin and watery. der, dated 2/4/22 indicated the Practitioner) to evaluate and ress check settings every shift,			DBE COMPLETION DATE DATE	
	medihoney to the s foam dressing. The physician's or discontinued on 4/ apply Dakin's solu	ser, pat dry and apply wound bed and cover with a der, dated 2/16/22 and /26/22, indicated staff were to tion 0.125%, 1 application we wound to the right buttock				

PRINTED: 06/01/2022 FORM APPROVED

	Г OF HEALTH AND HUN R MEDICARE & MEDIC.					FO	TED: 06/01/2022 RM APPROVED 1B NO. 0938-0391
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	DNSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMP	LETED
		155697	B. WI	NG		04/29	/2022
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER	ł		ITTLE LEAGUE BLVD SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	т	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	NATE	DATE
	discontinued on 4/1 use Silverasorb app a dry dressing. The physician's ordediscontinued on 12/ indicated staff were 250 units/grams, 1 a open area to the righ pat dry, and thick ni wound bed, cover we needed for soilage of The physician's ordediscontinued on 3/1 cleanse right buttoc dry. Apply Puracol wound bed and cover The physician's ordediscontinued on 3/1	er, dated 2/26/22 and 2/22, indicated staff were to ly to the wound bed and apply er, dated 11/1/21 2/2, and 2/24/22 to 3/10/22, to apply Santyl ointment, application topical, cleanse ant buttock with normal saline, ickel amount of Santyl to <i>v</i> ith foam dressing daily and as					

discontinued on 4/26/22, indicated staff were to cleanse the right buttock with normal saline, and pat dry. Apply wound vac at 125mmhg. Apply white foam to undermining, followed by black foam to the wound base and track the pad to the hip. During an interview, on 4/28/22 at 9:45 a.m., the wound NB indicated the wound was slow to head

wound NP indicated the wound was slow to heal due to the resident's nutritional status, weight loss, smoking, and staying up in wheelchair. The wound was stable except for tunneling. She was unsure at this time what stage the pressure wound was on 11/1/21. Her wound care notes for 11/1/21 indicated the wound was a stage III when found.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2HG111 Facility ID: 000059

000059

If continuation sheet

Page 20 of 35

0.00.100000			· · · · ·		ISTRA LIGHTON		
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	` <i>´</i>		NSTRUCTION	n í í	ATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		ILDING	00	CO	MPLETED
		155697	B. WI	NG		04/	/29/2022
NAME OF	PROVIDER OR SUPPLIEI	· · · · · · · · · · · · · · · · · · ·			DDRESS, CITY, STATE, ZIP COI	DE	
			- 0				
		AND SKILLED NURSING CENTI	Ξĸ		SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP		COMPLETIO
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	-	v, on 4/29/22 8:32 a.m., the					
		dent 51 had a lot of issues					
	going on health wis	se. Her Braden Scale for					
		Sore on admission indicated					
	the resident was at	high risk for pressure wounds.					
	The pressure woun	d should have been found and					
	documented before	it was found at a stage III.					
	During an interview	v, on 4/29/22 at 10:00 a.m.,					
	-	urse Caroline LPN (Licensed					
		licated a pressure injury					
		fore it's a stage III. On					
		skin assessment indicated					
		vas intact. The pressure					
		wound was documented on $11/1/21$ as a stage III.					
		kin assessments need to be					
	accurate.						
	The Skin Managen	nent Policy, dated 7/21,					
	-	2 at 12:50 p.m., by the DON,					
	-	ot limited to, "It is the					
		Corporation] to ensure that					
		ves care, consistent with					
		rds of practice, to prevent					
		does not develop pressure					
	-	dividual's clinical condition					
		hey were unavoidable; and a					
		are ulcers receives necessary					
	•	ces, consistent with					
		rd of practice, to promote					
	-	fection, and prevent new ulcers					
	from developing'	-					
	3.1-40(a)(1)						
0688	483.25(c)(1)-(3)						
55=D		Decrease in ROM/Mobility					
33–D 3ldg. 00	§483.25(c) Mobili	-					
Jug. 00		e facility must ensure that a					
		ers the facility without limited					
		as the racinty without infilled	1				

	NT OF DEFICIENCIES	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		00	(X3) DATE SURVEY COMPLETED 04/29/2022	
	PROVIDER OR SUPPLIE	R AND SKILLED NURSING CENTE	ĒR	517 N	ADDRESS, CITY, STATE, ZIP CODE LITTLE LEAGUE BLVD (SVILLE, IN 47129		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETI DATE
	reduction in rang resident's clinica a reduction in ran unavoidable; and §483.25(c)(2) A for of motion receives services to increa- to prevent further motion. §483.25(c)(3) A for receives appropri- and assistance to mobility with the independence un- is demonstrably Based on observat interview, the faci (Range of Motion) recommended for Range of Motion. Findings Include: During an observat contracted, with a the palm of the res- indicated he had a supposed to use by had trouble getting During an observat the resident was hy to his contracted r	resident with limited range es appropriate treatment and ase range of motion and/or r decrease in range of resident with limited mobility iate services, equipment, o maintain or improve maximum practicable nless a reduction in mobility unavoidable. ion, record review, and lity failed to ensure ROM 0 devices were applied as 1 of 3 residents reviewed for (Resident 34) tion on $4/25/22$ at 1:06 p.m., <i>y</i> ing abed. His right hand was thick, yellow, scaly build up to idents hand. The resident palm protector, he was at couldn't get it on himself and g anyone to put it on him. tion on $4/26/22$ at 8:28 a.m., ring abed with no splint in place	F 0	588	F688 What corrective action(s) w be accomplished for those residents found to have bee affected by the deficient practice: • Resident 34 no longer resides in the facility How other residents having potential to be affected by t same deficient practice will identified and what correcti action(s) will be taken: • All residents with recommendations for splints the potential to be affected by alleged deficient practice. • An audit was completed by DNS to identify all residents of recommendations for splints,	the he be ve have y the y	05/29/20

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155697	B. WING	<u></u>	04/29/2022
NAME OF	PROVIDER OR SUPPLI	- R	STREET	ADDRESS, CITY, STATE, ZIP CODE	
				LITTLE LEAGUE BLVD	
CLARK I	REHABILITATION	AND SKILLED NURSING CENTE	R CLAR	KSVILLE, IN 47129	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		ENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETI
TAG		DR LSC IDENTIFYING INFORMATION)	TAG		DATE
	to his contracted r	ight hand.		ensure that devices have	
	During on observe	ation on 4/28/22 at 9:03 a.m.,		physician orders, are care planned for use, and are curre	ntly
	-	ying abed with no splint in place		using the device.	inuy
	to his contracted r			·All nursing staff have been	
		ight hand.		educated by DNS/designee or	
	During an observe	ation on 4/29/22 at 9:01 a.m., .,		splint use and policy.	
	U U	ying abed with no splint in place		spinit use and policy.	
	to his contracted i			What measures will be put in	to
		ight hund.		place and what systemic	
	The clinical recor	d for Resident 34 was reviewed		changes will be made to ens	ure
		0 a.m. The diagnoses included,		that the deficient practice do	
		ed to, lumbago with sciatica to		not recur:	
		ndylosis with radiculopathy,		· All nursing staff have be	en
		r disease, abnormal posture,		educated by DNS/designee or	
		opathic neuropathy, need for		splint use and policy.	
		rsonal care, muscle weakness,		DNS/designee will	
	and chronic pain s			complete daily audit to ensure	
	-	-		residents utilizing splints have	the
	The Significant C	hange MDS (Minimum Data		devices available and are utiliz	zing
	Set) assessment, d	lated 3/14/22, indicated the		per order, with follow up	
	resident was cogn	itively intact and did not		notifications completed for any	/
		ional limitation in range of		refusals.	
	motion to the resi	dent's upper extremities.			
				How the corrective action(s)	
		dated 2/18/22 at 12:15 p.m.,		will be monitored to ensure t	he
		y meeting had been held with		deficient practice will not	
	_	sident. His extremities had		recur: QA	
	contractures.			DNS/designee will complete	ch c
	The numeric moto	dated 3/17/22 at 12:21 p.m.,		Range of Motion QA tool week for 8 weeks, monthly for 6 more	-
		y meeting was held with		and quarterly for 2 quarters. T	
		had ordered a splint for the		results of these audits will be	ne
		quest, and had provided		reviewed by the QAPI Commit	tee
	_	on donning and doffing the		overseen by the ED. If thresh	
	splint.	on coming and coming the		of 95% is not achieved, an act	
	spinit.			plan will be developed to ensu	
	The clinical recor	d lacked documentation of any		compliance.	·~
		off the splint, to monitor the			
		s of skin breakdown, any		Attachments: D, H, I	
	and for any sign	s er enni er our ao mi, un y			

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 06/01/2022

 FORM APPROVED

 OMB NO. 0938-0391

	TERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DA7	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	A. BUILDING <u>00</u>		COMPLETED	
		155697	B. WING	B. WING		04/29/2022	
NAME OF	PROVIDER OR SUPPLIEI	٠ ۲			ADDRESS, CITY, STATE, ZIP COD	3	
		AND SKILLED NURSING CENT			ITTLE LEAGUE BLVD SVILLE, IN 47129		
	-				SVILLE, IN 47 129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)		REFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETI DATE
IAU		ucation on refusal of the		IAU	May 29, 2022		DATE
		n to address the resident's			Way 29, 2022		
	contractures and sp						
	During an interview	v, on 4/28/22 at 11:12 a.m.,					
	LPN (Licensed Pra	ctical Nurse) 8 indicated she					
		esident had a splint, she felt					
		one but she was not sure, she					
	would have to chec	k and see.					
	During an interview	v, 4/28/22 at 11:57 a.m.,					
	-	ndicated the resident's arms					
	<u>^</u>	ney had gotten a splint for					
		be in his room still. The					
		ted it, and then decided he					
	didn't like it.						
	During on interview	v, on 4/28/22 at 2:38 p.m., the					
	-	v, on 4/28/22 at 2:38 p.m., the virector of Clinical Services)					
		ent should have had an order to					
		he splint, and to monitor the					
	-	of the splint should have been					
	documented.						
	-	v, on 4/29/22 at 8:20 a.m., the					
		Nursing), indicated they did					
		r from hospice for donning or					
		f they had gotten an order, ad an order to don and doff the					
		ne site for breakdown. The					
	-	d been wearing the splint.					
	3.1-42(a)						
0695	483.25(i)						
SS=D	Respiratory/Trach	eostomy Care and					
Bldg. 00	Suctioning						
		ratory care, including					
		e and tracheal suctioning.					
	I The facility must e	ensure that a resident who					1

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155697 B. WING 04/29/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 517 N LITTLE LEAGUE BLVD CLARK REHABILITATION AND SKILLED NURSING CENTER CLARKSVILLE. IN 47129 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on record review, and interview, the F 0695 05/29/2022 F-695 facility failed to ensure interventions and assessments were implemented to prevent the development or worsening of respiratory What corrective action(s) will be accomplished for those residents symptoms for 1 of 3 residents reviewed for respiratory care. (Resident 36) found to have been affected by the deficient practice? Findings include: Resident 36 received The clinical record for Resident 36 was reviewed appropriate interventions to manage acute respiratory on 4/26/22 at 1:15 p.m. The diagnoses included, but were not limited to, diabetes mellitus, stage 5 symptoms, and is being monitored chronic kidney disease, end stage renal disease, for further respiratory symptoms. muscle weakness, coronary artery disease, obstructive sleep apnea, chronic diastolic How other residents having the potential to be affected by the (congestive) heart failure, hypertension, paroxysmal atrial fibrillation, acute and chronic same deficient practice will be identified and what corrective respiratory failure with hypercapnia. action(s) will be taken? The Quarterly MDS (Minimal Data Set) assessment, dated 12/17/21, indicated the All residents with a change in condition have the potential to resident was cognitively intact. be affected by the alleged The care plan, dated 3/22/22, indicated the deficient practice. resident was the resident was at risk for fluid An audit was completed by imbalance due to decreased mobility, weakness, DNS and IDT to identify all diabetes mellitus, congestive heart failure and residents with a change of chronic kidney disease. The interventions condition to ensure appropriate follow up and MD notification has included, but were not limited to administer medications as ordered, document and notify been completed. physician of signs and symptoms of fluid volume All nursing staff have been educated by DNS/designee on the deficit: dry mucous membranes, thirst, weight Change of Condition Policy which loss, decrease blood pressure, weak/rapid pulse,

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155697 B. WING 04/29/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 517 N LITTLE LEAGUE BLVD CLARK REHABILITATION AND SKILLED NURSING CENTER CLARKSVILLE. IN 47129 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) change in mental status, decreased urine output, includes appropriate follow up abnormal labs, poor skin turgor, encourage assessments and timely MD notification. fluids, labs as ordered, and record intake. The physician's orders indicated the resident was What measures will be put into prescribed the following: place or what systemic changes will be made to ensure that the - Pulmicort Flexhaler 180 mcg/actuation, 1 puff deficient practice does not recur? inhalation for acute and chronic respiratory failure with hypercapnia with a start date of All nursing staff have been 2/9/22 and a discontinue date of 2/25/22. educated by DNS/designee on the Change of Condition Policy which - Pulmicort Flexhaler 180 mcg/actuation, 1 puff includes appropriate follow up assessments and timely MD inhalation for acute and chronic respiratory notification. failure with hypercapnia with a start date of DNS/designee will audit all 3/9/22. Replace Bipap/Cpap mask/nasal prongs, tubing, medical records of current residents daily to ensure any and filter every 3 months. changes of condition receive The NP (Nurse Practitioner) progress notes, appropriate follow up assessments dated 2/4/22, indicated the resident was seen for and MD notification. evaluation related to reports of right lower leg How the Corrective action(s) will swelling. He was currently on Bumex 2 (milligrams) daily. She would adjust the Bumex be maintained to ensure the deficient practice will not recur: orders for 5 days and update laboratory tests following treatment. QA The DNS/designee will complete the Change of Condition CQI tool The nurse's note, dated 2/5/22 at 8:46 a.m., weekly for 8 weeks, monthly for 6 indicated the resident's entire body continued to be swollen. The resident complained of months and then quarterly for 2 increased episodes of being short of breath. His quarters. The results of these oxygen saturations were ranging between 91 to audits will be reviewed by the 97% (percent on 2 lpm (liters per minute) per QAPI Committee overseen by the nasal cannula. The resident was encouraged to ED. If threshold of 95% is not limit fluid and sodium intake. achieved an action plan will be developed to ensure compliance The nurse's note, dated 2/21/22 at 1:15 a.m., indicated the resident continued to have some Attachments: A, D, E shortness of breath. The head of his bed was May 29, 2022 elevated to facilitate with his breathing. His skin

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Event ID:

2HG111 Facility II

Facility ID: 000059

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	IN OR DESIGN						mp ar	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	È É		NSTRUCTION		(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER:		JILDING	00	_		
		155697	B. W.			_	/29/2022	
NAME OF	PROVIDER OR SUPPLIE	2			DDRESS, CITY, STATE, ZIP C	CODE		
					TTLE LEAGUE BLVD			
CLARK	CLARK REHABILITATION AND SKILLED NURSING CENTE		ER	CLARKS	SVILLE, IN 47129			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COR	RECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE	COMPLET	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	-	odomen was extremely large						
	-	t leg was taunt and swollen.						
		ot get up out of bed much						
	anymore due to dif	ficulty breathing.						
	The clinical record	lacked documentation of						
	other intervention of							
	assessments.							
		ated 2/23/22 at 7:00 p.m.,						
		was summoned to the						
		the CNA (Certified Nurse						
		complained of increased						
		. He had facial swelling and						
		due to the swelling. He was						
		muscles to breath. His O2						
	-	etween 77 to 80% on 4 lpm						
	-	Orders were received to send						
		ocal hospital due to possible						
	respiratory failure.							
	The NP progress no	otes, dated 3/9/22 at 12:39						
		resident was seen for an						
	admission assessm	ent after return from the local						
	hospital due to flui	d overload and chronic kidney						
	disease.							
	During on interview	v, dated 4/29/22 at 8:30 a.m.,						
	-	of Nursing) indicated the						
		ave been addressed when						
		in condition. The NP and						
	e	been called when the						
	resident's symptom							
	5 1							
	The Resident Chan	ge of Condition Policy, dated						
	11/20/18, provided	on 4/28/22 at 12:50 p.m., by						
	the DON, included	, but was not limited to, " It						
	is the policy of this	facility that all changes in						
	resident condition	will be communicated to the						
		ly responsible party, and that						

ENTERS FOR MEDICARE & MEDICAID SERVICES						, i	OMB NO. 0938-03
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DA'	TE SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A. BUILDING 00		COMPLETED	
		155697	B. WING			04/29/2	
				STREET A	ADDRESS, CITY, STATE, ZIP CO	DDE	
NAME OF I	PROVIDER OR SUPPLIEI	2			ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENT	ER		SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO		COMPLETIC
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE AF DEFICIENCY)		DATE
		e interventions takes place"					
		F					
	3.1-47(a)(6)						
0755	483.45(a)(b)(1)-(3	3)					
SS=D	Pharmacy						
Bldg. 00	Srvcs/Procedures	/Pharmacist/Records					
	§483.45 Pharmac	y Services					
	The facility must	provide routine and					
	emergency drugs	and biologicals to its					
	residents, or obta	in them under an					
	agreement descri	bed in §483.70(g). The					
	-	t unlicensed personnel to					
		if State law permits, but					
		neral supervision of a					
	licensed nurse.						
	§483.45(a) Proce	dures. A facility must					
	,	eutical services (including					
		ssure the accurate					
		ng, dispensing, and					
		Ill drugs and biologicals) to					
	meet the needs o	c v <i>i</i>					
	meet the needs o						
	§483.45(b) Servic	e Consultation. The facility					
	must employ or o	btain the services of a					
	licensed pharmac	ist who-					
	\$492 45/b)/1) Dro	vides consultation on all					
		ovision of pharmacy					
	services in the fac	ciirty.					
	8483 45(b)(2) Est	ablishes a system of					
		and disposition of all					
		n sufficient detail to enable					
	an accurate recor						
		termines that drug records					
		hat an account of all					
	controlled drugs is	n maintained and	1				1

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 00 B. WING 04/29/2022 155697 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 517 N LITTLE LEAGUE BLVD CLARK REHABILITATION AND SKILLED NURSING CENTER CLARKSVILLE. IN 47129 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) periodically reconciled. Based on observation, record review and F 0755 F755 05/29/2022 interview, the facility failed to ensure insulin pens were appropriately labeled and discarded What corrective action(s) will be accomplished for those upon expiration for 2 of 4 medication carts observed for medication storage. (Resident 29) residents found to have been affected by the deficient Findings include: practice: Staff are following policy for expiration of insulin pens for 1. During an observation on 4/27/22 at 11:13 a.m., LPN (Licensed Practical Nurse) 6 prepared Resident 29 to administer Resident 29's insulin aspart flexpen 100 units/mL (milliliters) per sliding scale, How other residents having the which had an open date of 2/18/22 on the pen. potential to be affected by the The pen expired on 3/28/22. LPN 6 had dialed same deficient practice will be the pen to 12 units when she was asked to check identified and what corrective the expiration date. Upon seeing the date, she action(s) will be taken: disposed of the flexpen in the sharps container ·All residents receiving insulin have the potential to be affected and obtained the resident's unopened flexpen. by the alleged deficient practice. The clinical record for Resident 29 was reviewed ·An audit was completed by on 4/27/22 at 1:02 p.m. The diagnoses included, DNS and IDT to identify all residents receiving insulin to but were not limited to, type 2 diabetes mellitus with foot ulcer, diabetic neuropathy, and diabetic ensure all insulin devices are autonomic (poly)neuropathy. labeled with appropriate opened date and are within date The Quarterly MDS (Minimum Data Set) parameters assessment, dated 3/4/22, indicated the resident ·All licensed nursing staff were educated by DNS/designee on was cognitively intact. proper insulin pen storage, The care plan, dated 9/10/21 and last revised on expiration and disposal. 3/10/22, indicated the resident was at risk for adverse effects of hyperglycemia or What measures will be put into place and what systemic hypoglycemia related to use of glucose lowering medication and/or diagnosis of diabetes mellitus. changes will be made to ensure The interventions, dated 9/10/21, included, but that the deficient practice does were not limited to, document abnormal findings not recur: All licensed nursing staff and notify MD, labs as ordered, medications as ordered, monitor blood sugars as ordered, were educated by DNS/designee observe for symptoms of hyperglycemia. on proper insulin pen storage,

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 00 155697 B. WING 04/29/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 517 N LITTLE LEAGUE BLVD CLARK REHABILITATION AND SKILLED NURSING CENTER CLARKSVILLE, IN 47129 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) expiration and disposal. The current physician's orders included, but were DNS/designee will complete not limited to, the following: daily audit to ensure that insulin Insulin aspart U-100 insulin pen; 100 unit/mL (3 devices are labeled with appropriate opened date and are mL); amount: per sliding scale; If blood sugar was less than 60, call MD. If blood sugar was 61 within date parameters. to 199, give 0 units. If blood sugar was 200 to 250, give 3 units. If blood sugar was 251 to 300, How the corrective action(s) give 6 units. If blood sugar was 301 to 350, give will be monitored to ensure the 9 units. If blood sugar was 351 to 400, give 12 deficient practice will not units. If blood sugar was greater than 400, give recur: QA DNS/designee will complete the 15units. If blood sugar was greater than 400, call MD. subcutaneously four times a day, starting Medication Storage Review QA 2/17/22. tool weekly for 8 weeks, monthly for 6 months and the quarterly for Lantus Solostar U-100 Insulin (insulin glargine) 2 guarters. The results of these insulin pen; 100 unit/mL (3 mL); amount: 40 audits will be reviewed by the QAPI Committee overseen by the units; subcutaneously, twice a day, starting ED. If threshold of 95% is not 4/13/22. achieved, an action plan will be The resident's blood sugars for March 2022 developed to ensure compliance. indicated an average range of 300 to 400 mg/dl. Attachments: D, J, K She received the insulin aspart 4 times daily May 29, 2022 from 3/29/22 to 4/26/22. The New Order Documentation, dated 3/1/22, indicated an increase of the Lantus to 40 units BID (twice daily), due to abnormal blood glucose. During an interview, on 4/27/22 at 11:13 a.m., LPN 6 indicated the resident's blood sugars were high and she always required insulin. 2. During an observation, on 4/27/22 at 11:22 a.m., an unlabeled Lantus insulin pen, with an open date of 3/24/22, was found in the Front Hall medication cart. The pen expired on 4/21/22. The insulin pen did not contain any pharmacy FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 2HG111 Facility ID: 000059 If continuation sheet Page 30 of 35

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OT ATEL (E)	AT OF DEFICIENCIES	V1) DROWIDED (CURDUED (CULA		TIDLE CO	ISTRUCTION	(VA) D +	TE CUDVEN	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPLETED		
		155697	B. WING		04/29/2022			
NAME OF	PROVIDER OR SUPPLIEI	R	STREET ADDRESS, CITY, STATE, ZIP CODE			DE		
		AND SKILLED NURSING CENTE			TTLE LEAGUE BLVD SVILLE, IN 47129			
	-				SVILLE, IN 47 129			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRE		(X5)	
PREFIX		VCY MUST BE PRECEDED BY FULL	Р	REFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP		COMPLETIC	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	0.	nformation, or directions for						
	use.							
	During an interview	v, on 4/27/22 at 1:33 p.m., the						
	-	Director of Clinical Services)						
		not locate which resident the						
		. They could have been						
	discharged from the	-						
		Preparation and Medication						
	-	icy, last revised on 1/1/13,						
		e Regional Director of						
		n 4/27/22 at 1:10 p.m. The						
		t was not limited to, " 3.3						
		d not administer a medication r prescription label is missing						
		ty staff should verify that the						
	-	4. Prior to administration of						
		v staff should take all						
		by facility policy Check the						
	expiration date on t							
	-	e Recommendations,						
		was provided by the RDCS on						
	-	h. The insulin Aspart indicated						
		period of 28 days. The Lantus						
	insulin had an open	expiration period of 28 days.						
	3.1-25(k) (1)							
	3.1-25(k)(2)							
	3.1-25(k)(3)							
	3.1-25(k)(5)							
	3.1-25(o)							
0791	483.55(b)(1)-(5)							
SS=D		cy Dental Srvcs in NFs						
31dg. 00	§483.55 Dental S	•						
Jiag. 00	-	assist residents in obtaining						
		our emergency dental care.						

CTATE I	NT OF DEFICIENCIES	V1) DDOVIDED (GUDDI IED (CLIA	(VO) 1 0	ULTINE CO	NETHICTION	(172) D	ATE CUDVEN	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î /		NSTRUCTION	<u> </u>	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		JILDING	00	_	MPLETED	
		155697	B. WI	NG		_ 04	/29/2022	
NAME OF	PROVIDER OR SUPPLIEI	}		STREET A	DDRESS, CITY, STATE, ZIP O	CODE		
					ITTLE LEAGUE BLVD			
CLARK	REHABILITATION	AND SKILLED NURSING CENT	ER	CLARKS	SVILLE, IN 47129			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COF	RRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE		COMPLET	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	§483.55(b) Nursir The facility-	ng Facilities.						
	8483 55(b)(1) Mu	st provide or obtain from an						
		in accordance with						
		part, the following dental						
		he needs of each resident:						
	(i) Routine dental	services (to the extent						
	covered under the	e State plan); and						
	(ii) Emergency de	ntal services;						
	§483.55(b)(2) Mu	st, if necessary or if						
	requested, assist							
	(i) In making appo							
		or transportation to and						
	from the dental se	ervices locations;						
	§483.55(b)(3) Mu	st promptly, within 3 days,						
		th lost or damaged dentures						
	for dental services	s. If a referral does not						
		/s, the facility must provide						
		what they did to ensure the						
		l eat and drink adequately						
		ntal services and the						
	delay;	mstances that led to the						
		st have a policy identifying						
		ces when the loss or						
	damage of dentur							
	-	may not charge a resident						
	for the loss or dar							
	determined in acc	ordance with facility policy						
	to be the facility's	responsibility; and						
		st assist residents who are						
	-	to participate to apply for						
		dental services as an						
		expense under the State						
	plan.							

DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUMMARY S	AND SKILLED NURSING CENTE	517 N	ADDRESS, CITY, STATE, ZIP CODE	DMPLETED 1/29/2022
EHABILITATION A SUMMARY S (EACH DEFICIE)	R AND SKILLED NURSING CENTE	STREET 517 N	ADDRESS, CITY, STATE, ZIP CODE	/29/2022
EHABILITATION A SUMMARY S (EACH DEFICIE)	AND SKILLED NURSING CENTE	517 N		
EHABILITATION A SUMMARY S (EACH DEFICIE)	AND SKILLED NURSING CENTE			
SUMMARY S			LITTLE LEAGUE BLVD	
(EACH DEFICIE)			SVILLE, IN 47129	
	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
REGULATORY O	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	eview and interview, the	F 0791	F791	05/29/2022
-	sure dental services were		-	
	y manner for 1 of 3 residents		What corrective action(s) will	
reviewed for denta	l services. (Resident 24)		be accomplished for those	
			residents found to have been	
Findings include:			affected by the deficient	
			-	
			-	
depressive episode	es.		house dental referral.	
			 Resident 24 has 	
The Significant Ch	nange MDS (Minimum Data		appointment made to see oral	
Set) assessment, da	ated $2/1/22$, indicated the		surgeon on 6/1/22; resident	
resident was cogni	tively intact and had obvious		and/or family notified.	
or likely cavity or	broken teeth.			
			How other residents having the	
During an intervie	w, on 4/25/22 at 11:09 a.m.,		potential to be affected by the	
Resident 24 indica	ted he had several missing		same deficient practice will be	
teeth and couldn't	get treatment because the		identified and what corrective	
facility told him he	e had the wrong insurance. He		action(s) will be taken:	
was supposed to be	e getting dentures for three		·All residents have the potential	
years now. At one	point he'd been in the dentist		to be affected by the alleged	
chair, about to hav	e surgery, and they had to take		deficient practice.	
			Audit completed by SSD of	
cleared.	-		all residents in facility to identify	
			immediate dental needs.	
The nurse's note, d	lated 9/24/20 at 10:47 a.m.,		· All staff educated by	
			-	
			-	
-	8			
- •			What measures will be put into	
The dental exam, o	lated 2/12/21, indicated a		place and what systemic	
			changes will be made to ensure	
-			that the deficient practice does	
•			not recur:	
-	-		-	
	The clinical record on 4/27/22 at 10:00 but were not limite and need for assist depressive episode The Significant CH Set) assessment, de resident was cogni or likely cavity or During an intervie Resident 24 indicat teeth and couldn't facility told him he was supposed to be years now. At one chair, about to hav him out because the cleared. The nurse's note, de indicated the resid dentist and had ner was placed to the of appointment. The dental exam, of referral had been p with the pandemic to go. The SSD (St thought he would be	The clinical record for Resident 24 was reviewed on 4/27/22 at 10:00 a.m. The diagnoses included, but were not limited to, type 1 diabetes mellitus and need for assistance with personal care, depressive episodes. The Significant Change MDS (Minimum Data Set) assessment, dated 2/1/22, indicated the resident was cognitively intact and had obvious or likely cavity or broken teeth. During an interview, on 4/25/22 at 11:09 a.m., Resident 24 indicated he had several missing teeth and couldn't get treatment because the facility told him he had the wrong insurance. He was supposed to be getting dentures for three years now. At one point he'd been in the dentist chair, about to have surgery, and they had to take him out because they couldn't get the insurance cleared. The nurse's note, dated 9/24/20 at 10:47 a.m., indicated the resident was seen on 9/22/20 by the dentist and had new orders for extractions. A call was placed to the oral surgeon for an	The clinical record for Resident 24 was reviewed on 4/27/22 at 10:00 a.m. The diagnoses included, but were not limited to, type 1 diabetes mellitus and need for assistance with personal care, depressive episodes. The Significant Change MDS (Minimum Data Set) assessment, dated 2/1/22, indicated the resident was cognitively intact and had obvious or likely cavity or broken teeth. During an interview, on 4/25/22 at 11:09 a.m., Resident 24 indicated he had several missing teeth and couldn't get treatment because the facility told him he had the wrong insurance. He was supposed to be getting dentures for three years now. At one point he'd been in the dentist chair, about to have surgery, and they had to take him out because they couldn't get the insurance cleared. The nurse's note, dated 9/24/20 at 10:47 a.m., indicated the resident was seen on 9/22/20 by the dentist and had new orders for extractions. A call was placed to the oral surgeon for an appointment. The dental exam, dated 2/12/21, indicated a referral had been placed for extractions, however with the pandemic the resident had not been able to go. The SSD (Social Services Director) thought he would be able to at some point.	Findings include:affected by the deficient practice:The clinical record for Resident 24 was reviewed on 4/27/22 at 10:00 a.m. The diagnoses included, but were not limited to, type 1 diabetes mellitus and need for assistance with personal care, depressive episodes.· Resident 24 will have an appointment made to outside dental office for consultation to have teeth extracted as listed by in house dental referral. · Resident 24 has appointment made to see oral surgeon on 6/1/22; resident and/or family notified.The Significant Change MDS (Minimum Data Set) assessment, dated 2/1/22, indicated the resident was cognitively intact and had obvious or likely cavity or broken teeth.How other resident 34 has appointment made to see oral surgeon on 6/1/22; resident and/or family notified.During an interview, on 4/25/22 at 11:09 a.m., Resident 24 indicated he had several missing teeth and couldn't get treatment because the facility told him he had the wrong insurance. He was supposed to be getting dentures for three years now. At one point he'd been in the dentist chair, about to have surgery, and they had to take him out because they couldn't get the insurance cleared.How other resident shave the potential to be affected by the alleged deficient practice.The nurse's note, dated 9/24/20 at 10:47 a.m., indicated the resident was seen on 9/22/20 by the dentist and had new orders for extractions. A call was placed to the oral surgeon for an appointment.SDI/designee on Dental Services policy which includes addressing immediate dental needs.The dental exam, dated 2/12/21, indicated a referral had been placed for extractions, howver with the pandemic the resident thad not been able to go. The SSD (Social Services Director) thought

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155697 B. WING 04/29/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 517 N LITTLE LEAGUE BLVD CLARK REHABILITATION AND SKILLED NURSING CENTER CLARKSVILLE, IN 47129 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 11, 12, 14, 21, 22, 23, 25, 26, 27, and 31. Teeth policy which includes addressing 2, 3, 8, 19, 20, 4, and 28 would remain and immediate dental needs. SSD/designee will appliances would be fabricated after healing was complete daily audit of Facility complete. Activity Report to ensure residents' dental needs are The nurse's note, dated 2/15/21 at 10:47 a.m., addressed. indicated the resident was seen on 2/12/21 by the dentist and the oral surgeons appointment was How will the corrective rescheduled for 4/19/21. action(s) be monitored to The nurse's note, dated 4/19/21 at 4:19 p.m., ensure the deficient practice indicated the resident returned from the dental will not recur: QA appointment and his extractions had been unable SSD/Designee will complete the to be completed because of issues with billing. Dental Services QA Tool weekly for 8 weeks, monthly for 6 months The resident was open to being removed from the facilities dental program and seeing an outside and quarterly for 2 quarters. The dentist if necessary. The facility would continue results of these audits will be reviewed by the QAPI Committee to assist. overseen by the ED. If threshold The dental exam, dated 10/25/21 indicated the of 95% is not achieved, an action plan will be developed to ensure resident had root tips present on 4, 5, 9, 10, 11, 12, 14, 21, 22, 23, 25, 26, 27, and 31. His oral compliance. hygiene was poor. The resident had natural teeth with poor oral health and several root tips Attachments: D, L, M remaining. No pain or infection at the time. The May 29, 2022 recommendation indicated to continue 6 month exams, and refer to oral surgeon for extractions. The clinical record lacked documentation of any efforts by the facility to assist the resident with his insurance or dental extractions at this time. The dental exam note, dated 3/4/22, indicated the patient had a significant number of broken teeth he would like extracted so he could eat better with dentures. The SSD requested referral for office. A referral was submitted. During an interview, on 4/28/22 at 9:39 a.m., Unit Manager 7 indicated the SSD had given her a

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DEPARTMENT O	F HEALTH AND	HUMAN SERVICES	

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-0391			
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE	SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. B	JILDING	00	COMPI	LETED			
		155697	B. W	B. WING 04/29/2022						
NAME OF P	NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE					
				517 N LITTLE LEAGUE BLVD						
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTE	К	CLARKSVILLE, IN 47129						
(X4) ID	(4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID			(X5)			
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION			
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	AIE	DATE			
	referral for the resid	lent to have extractions on								
		o call the Oral Surgeon but he								
		see the resident until his								
	insurance was chan									
		6								
	During an interview, on 4/28/22 at 9:44 a.m., the									
	-	had only been the SSD since								
		id was not aware the resident								
		ered back in 2020. She was								
		h billing and his extractions.								
		prevented him from billing for								
	extractions.									
	The Dental Service	s/Missing Dentures Policy,								
		provided on $4/28/22$ at								
		DCS (Regional Director of								
	-	included, but was not limited								
		facility obtains needed dental								
		routine and emergency dental								
		÷.								
	services; assists in providing these services and makes prompt referrals for dental services as									
		cility will obtain contracted								
		ces to meet the routine and								
		eeds of each resident"								
	emergency dentar in	ion of our residential								
	3.1-24(a)(3)									
	211 21(4)(2)									
	1		1		1		1			

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