STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155697	A. BUILDING 00 B. WING	06/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00350116 and IN00351872. Complaint IN00350116 - Unsubstantiated due to lack of sufficient evidence. Complaint IN00351872 - Substantiated. Federal/State deficiencies related to the allegations are cited at F580, F641, and F656. Survey dates: May 28, and June 1, 2021 Facility number: 000059 Provider number: 155697 AIM number: 100266560 Census Bed Type: SNF/NF: 59 Total: 59 Census Payor Type: Medicare: 5 Medicaid: 42 Other: 12 Total: 59 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 4, 2021.	F 0000		
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its			

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	admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on interview and record review, the facility failed to ensure the family was notified when a resident's (Resident B) g-tube (gastrostomy tube) became dislodged and failed to ensure the physician was notified, in a timely manner, of a resident's need to transfer to the hospital for reinsertion of a g-tube for 1 of 3 residents reviewed for notification of change in condition. Findings include: The clinical record for Resident B was reviewed on 5/28/21 at 1:56 p.m. Diagnoses included, but were not limited to, anoxic brain damage, anxiety, and gastrostomy status. The progress note, dated 11/1/20 at 3:06 p.m., indicated the resident had pulled out her g-tube twice during the shift and staff reinserted the g-tube each time. The progress note, dated 11/17/20 at 3:20 a.m., indicated the resident had pulled out her g-tube and the g-tube was reinserted. The progress note, dated 11/20/20 at 6:09 a.m., indicated during incontinent care the resident pulled out her g-tube and the g-tube was reinserted. The progress note, dated 3/16/21 at 12:00 a.m., indicated during rounds the resident was found to have pulled out her g-tube and the g-tube was reinserted.	F 0580	F-580 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident E no longer resides at the facility. 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. · Interdisciplinary team reviewed all residents for a change of condition in the last 30 days for timely MD/family notification and made corrections as needed. · Nursing staff have been educated on the Change of Condition Policy which includes timely MD/family notification. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	07/01/2021

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	The progress note, dated 4/11/21 at 8:00 p.m., indicated the resident's g-tube would not flush, was removed, and a new g-tube was reinserted. The clinical record lacked documentation of an as needed order for tube reinsertion or family notification of the dislodgement and reinsertion of the g-tube. During an interview on 6/1/21 at 1:00 p.m., the RDCS (Regional Director of Clinical Services), indicated if a g-tube becomes dislodged and there was an order to replace it as needed, the family would not have to notified. If there was not an order, the family would be notified. The progress note, dated 4/16/21 at 4:15 a.m., indicated the resident's g-tube had been pulled out, and due to resistance, was unable to be reinserted and the nurse practitioner would be notified. The progress note, dated 4/16/21 at 6:04 a.m., indicated the nurse practitioner was notified and a new order received to send the resident out to the hospital for g-tube reinsertion. The progress note, dated 4/16/21 at 7:38 a.m., indicated the resident left the building at 7:07 a.m. for the hospital. During an interview on 6/1/21 at 2:33 p.m., the Executive Director indicated she was unsure of why there was a delay in sending the resident out for g-tube replacement. On 6/1/21 at 1:29 p.m., the Executive Director provided a current copy of the document titled "Resident Change of Condition Policy" dated		· Nursing staff have been educated on the Change of Condition Policy which includes timely MD/family notification. · DNS/designee will audit facility activity report daily to monitor resident change of condition and proper notification for 4 weeks, then bi-weekly for 2 months then monthly for 6 months. 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? · The DNS/designee will audit facility activity report daily to monitor resident change of condition and proper notification for 4 weeks, then bi-weekly for 2 months, then monthly for 6 months. · The DNS/designee will complete the Change of Condition CQI tool weekly for 4 weeks, bi-monthly for 2 months, monthly for 6 months and then quarterly. The results of these audits will be reviewed by the QAPI Committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance Attachments A, B, C July 1, 2021	

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	11/2018. It included, but was not limited to, "Policy...It is the policy of this facility that all changes in resident condition will be communicated to the physician and family...an that appropriate, timely, and effective intervention takes place." This Federal tag relates to Complaint IN00351872 3.1-5(a)(3)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.			
	Based on interview and record review, the facility failed the ensure residents' (Residents B and E) MDS (Minimum Data Set) assessment accurately reflected the assistance needed for meal intake for 2 of 3 residents reviewed for accuracy of assessments. Findings include: 1. The clinical record for Resident B was reviewed on 5/28/21 at 1:56 p.m. Diagnoses included, but were not limited to, NPO (nothing by mouth), dysphasia, right sided hemiparesis, and gastrostomy (opening into the stomach, made surgically, for the introduction of food). The care plan, dated 4/16/19, indicated the resident was NPO and dependent on enteral nutrition. The annual MDS assessment, dated 3/19/21, indicated the resident required an extensive (resident assisted in the activity) one person physical assistance with eating.	F 0641	F-641 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Residents B and E no longer reside at the facility. 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. · All residents' ADL coding was audited for assistance for meal intake and corrections made as needed. · Nursing staff have been	07/01/2021

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	During an interview on 6/1/21 at 11:55 a.m., LPN (Licensed Practical Nurse) 4 indicated the resident was completely dependent on staff for all care and feedings. 2. The clinical record for Resident E was reviewed on 5/28/21 at 3:03 p.m. Diagnoses included, but were not limited to aphasia, left sided hemiparesis, and gastrostomy status. The physician's order, dated 12/10/20, indicated the resident was NPO. The care plan, dated 12/11/20, indicated the resident was on continuous enteral feedings and to administer tube feeding per physician's orders. The significant change MDS assessment, dated 3/15/21, indicated the resident required an extensive (resident assisted in the activity) one person physical assistance with eating. During an interview on 6/1/21 at 11:57 a.m., LPN 5 indicated the resident could not assist in any way with tube feedings. During an interview on 6/1/21 at 12:30 p.m., the MDS Coordinator indicated the MDS assessment for both Resident B and Resident E was inaccurate as the residents were dependent on staff for tube feedings. This Federal tag relates to Complaint IN00351872		educated on appropriate ADL coding for assistance for meal intake. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? · All nursing staff have been educated on appropriate ADL coding for assistance for meal intake. · DNS/designee will audit facility POC (Point of Care) report for appropriate ADL coding for assistance with meals daily for 4 weeks, then bi-weekly for 2 weeks then monthly for 6 months with discrepancies addressed as needed. 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? · DNS/designee will audit facility POC (Point of Care) report for appropriate ADL coding for assistance with meals daily for 4 weeks, then bi-weekly for 2 weeks then monthly for 6 months with discrepancies addressed as needed. · DNS/designee will complete the portion of the MDS	

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			Accuracy CQI tool that addresses ADL's weekly for 4 weeks, bi-weekly for 2 months, then monthly for 6 and then quarterly. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. Attachments D, E, F July 1, 2021	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's			

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	exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on interview and record review, the facility failed to implement a comprehensive plan of care for a resident (Resident E) for 1 of 3 residents reviewed for care plans. Findings include: The clinical record for Resident E was reviewed on 5/28/21 at 3:03 p.m. Diagnosis included, but was not limited to, gastrostomy status. Review of the physician's orders, dated 12/10/20, included the following: -Check residual every shift and hold feeding if residual is greater than 20 mL (milliliters) -Cleanse G-tube site with soap and water, pat dry	F 0656	F-656 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident E no longer resides at the facility 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?	07/01/2021

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	and apply gauze -Flush G-tube with at least 30 mL of H_2O (water) before and after medication administration -Change irrigation set -Check placement of G-tube -Elevate HOB (head of bed) 30-45 degrees at all times The clinical record lacked documentation for a plan of care related to the above orders. During an interview on 6/1/21 at 12:30 p.m., RN 3 indicated she could not find a plan of care that related directly to the resident's gastrostomy status . On 6/1/21 at 1:29 p.m., the Executive Director provided a current copy of the document titled "IDT Comprehensive Care Plan Policy" dated 10/2019. It included, but was not limited to, "Policy...It is the policy of this facility that each resident will have a comprehensive person-centered care plan developed based on comprehensive assessment. The care plan will include measurable goals and resident specific interventions based on resident needs...to promote the resident's highest level of functioning medical...nursing...needs...." This Federal tag relates to Complaint IN00351872 3.1-35(a) 3.1-35(b)(1) 3.1-35(c)(1)		· All residents have the potential to be affected by the alleged deficient practice. · An audit of all resident care plans who utilize gastrostomy tube was done to identify any areas of concerns and corrections made as needed. · Interdisciplinary Team has been educated on IDT Comprehensive Care Plan Policy and IDT Care Plan Review Guidelines including IDT Care Plan Pathways. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? · Interdisciplinary Team has been educated on IDT Comprehensive Care Plan Policy and IDT Care Plan Review Guidelines including IDT Care Plan Pathways. · DNS/designee will review residents who utilize gastrostomy tube care plans to ensure care plans meet resident’s needs for 5 residents weekly for 4 weeks, 5 residents bi-monthly, then 5 residents monthly for 6 months. 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? · DNS/designee will review	

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			residents who utilize gastrostomy tube care plans to ensure care plans meet resident's needs for 5 residents weekly for 4 weeks, 5 residents bi-monthly, then 5 residents monthly for 6 months. · DNS/designee will complete the Comprehensive Care Plan Review CQI tool for 4 weeks, bi-monthly for 2 months, monthly for 6 months then quarterly. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. Attachments G, H, I July 1, 2021	