STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155319	A. BUILDING 00 B. WING	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLINTON GARDENS	375 S 11TH ST CLINTON, IN 47842

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 12, 13, 14, 15, & 16, 2024 Facility number: 000212 Provider number: 155319 AIM number: 100285040 Census Bed Type: SNF/NF: 64 Total: 64 Census Payor Type: Medicare: 2 Medicaid: 45 Other: 17 Total: 64 These deficiencies reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 29, 2024.	F 0000	The filing of this plan of correction does not constitute an admission that the deficiencies did in fact exist. The plan of correction is filed as evidence of the community's desire to comply with the requirements and to continue to provide a safe and functional environment for our residents. Clinton Gardens would like to respectfully request a desk review of the following plan of correction.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp Based on observation, record review, and interview, the facility failed to ensure a self-administration assessment had been completed for a resident who was observed to self-administer her medications for 1 or 1 random observation (Resident 15). Findings include:	F 0554	The resident 15 observed was assessed for ability to self-administer and she was care planned appropriately. Other residents would have the potential to be affected by the deficient practice. Education was provided to all Nurses and QMAs via skills checkoff and education regarding medication	09/13/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Angela Brewer	Executive Director	09/11/2024

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	During a random observation of the breakfast meal in the main dining room, on 8/12/24 at 7:40 a.m., a medication cup containing 4 pills sat on the table in front of Resident 15. She self-administered the medications when her tray was delivered. No staff were present to observe the resident self-administer her medications. Resident 15's record was reviewed on 8/15/24 at 9:19 a.m. The profile indicated the resident's diagnoses included, but were not limited to, essential hypertension (a condition in which the blood vessels have persistently raised pressure), heart failure (a condition that occurs when the heart can't pump enough blood and oxygen to the body) and age-related macular degeneration (an eye disease that causes a breakdown of cells in the center of the retina, which is the light-sensitive tissue at the back of the eye). A quarterly Minimum Data Set (MDS) assessment, dated 7/17/24, indicated the resident had severe cognitive deficit and received medications, which included, but were not limited to, diuretic (a drug that increases the amount of urine the kidneys produce, helping the body get rid of extra fluid and salt) and antiplatelet (medications that prevent platelets from sticking together and forming blood clots). A review of the resident's record including assessments lacked documentation of an assessment to determine the resident's ability to self-administer medications. A review of the resident's record including care plans lacked documentation of her ability to self-administer her own medications. A review of the resident's record including		administration. All residents were reviewed by DNS/Designee to determine if any resident can self-administer medication. DNS/designee will round each shift to ensure medications are not left with the resident unless the resident was assessed to self-administer medications. QAPI tool will be completed weekly times 4 weeks, monthly times 6 and then quarterly for 2 quarters. 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.	

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	physician's orders lacked documentation of an order for Resident 15 to self-administer her medications. A physician's order, dated 5/21/24, indicated to administer one 75 milligram (mg) tablet of clopidogrel (antiplatelet medication), one time a day. A physician's order, dated 5/21/24, indicated to administer one 20 mg tablet of furosemide (diuretic medication), one time a day. A physician's order, dated 5/21/24, indicated to administer one 50 mg tablet of metoprolol succinate (antihypertensive medication), one time a day. A physician's order, dated 6/12/24, indicated to administer one Preservision AREDS 2 tablet (medication to treat moderate to advanced macular degeneration), one time a day. During an interview, on 8/12/24 at 9:29 a.m., the Resident 15 indicated she requested the nurses to leave her pills on her table for her to take later because she took a water pill. If she took the water pill prior to coming down for her meal, she ended up having to go to the bathroom in the middle of her meals. Some of the nurses had been leaving them on her table, but the nurse on the evening shift refused to leave the pills on the table for her. During an interview, on 8/15/24 at 10:12 a.m., the Director of Nursing (DON) indicated there were not any residents in the facility that self-administered their own medications. The nurses should know better than to leave medications for any resident to take without their supervision.			

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	During an interview, on 8/16/24 at 10:39 a.m., Licensed Practical Nurse (LPN) 16 indicated the residents must always be supervised when giving medications. During an interview, on 8/16/24 at 10:45 a.m., LPN 17 indicated medications should never be left for a resident to take unsupervised. On 8/15/24 at 10:38 a.m., the DON provided a document, with a revision date of 1/2015, titled, "Self Administration of Medications," and indicated it was the policy currently in use by the facility. The policy indicated, "...Procedure...If a resident desires to participate in self-administration, the Interdisciplinary Team will assess the competence of the resident to participate by completing the Self-Administration of Medication Assessment observation. A physician order will be obtained specifying the resident's ability to self-administer medications...The resident will be assessed for continued self-administration of medications quarterly and with any significant change of condition. The resident's care plan will be updated to include self-administration ...." 3.1-11(a)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on interviews and record reviews, the facility failed to ensure care plan meetings were completed timely for 2 of 24 residents reviewed for care plan meetings (Residents 12 and 24). Findings include:	F 0657	The residents 12 and 24 were offered a care plan meeting and will be conducted quarterly. All other residents would have the potential to be affected by the deficient practice. Education provided to the IDT regarding the	09/13/2024

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	1. During an interview on 8/12/24 at 11:10 a.m., Resident 12 indicated she could not remember having any care plan meeting in the last three years. On 8/13/24 at 2:24 p.m., Resident 12's record was reviewed. Care plan meeting documentation was located for 5/8/24, 2/13/24, and 9/11/23. The record lacked care plan meeting documentation from between 9/11/23 and 2/13/24. A quarterly Minimum Data Set (MDS) assessment, completed 7/29/24, indicated Resident 12 had a Brief Interview for Mental Status (BIMS) score of 14, indicating she was cognitively intact. During an interview on 8/14/24 at 10:39 a.m., the Social Services Director (SSD) indicated she might have done the assessment but did not complete the meeting note. During an interview on 8/14/24 at 11:17 a.m., the SSD indicated that she did not have any notes, documentation, or proof that the care plan meetings happened on paper or in the electronic medical record. During an interview on 8/14/24 at 12:01 p.m., the SSD indicated she did not do the care plan meetings at the time of the bedside assessments. She returned at another time to talk to do them. They did not use the care conference tab located in the electronic medical record. 2. During an interview, on 8/12/24 at 9:55 a.m., Resident 24 indicated he did not remember being invited to or attending a care plan meeting recently. He could not recall when the last one was. Resident 24's record was reviewed on 8/13/24 at		Care Plan Policy and Procedures. All other residents were checked to ensure care plan meetings are being offered and held quarterly by SSD/designee. ED/designee will review residents who are scheduled to have care plan meetings to ensure the care plan meetings are held quarterly and documented in the resident medical record. QAPI tool will be completed weekly times 4 weeks, monthly times 6 and then quarterly for 2 quarters. 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.	

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	1:47 p.m. A significant change in status, Minimum Data Set (MDS) assessment indicated the resident had moderate cognitive impairment. Census information indicated the resident was admitted to the facility on 2/8/23. A Care Plan Summary note, dated 4/17/24 at 4:26 p.m., indicated a care plan meeting was conducted on this day for Resident 24. A Care Plan Summary note, dated 6/19/24 at 9:44 a.m., indicated a care plan meeting was conducted on this day for Resident 24. Resident 24's record lacked documentation of a quarterly care plan meeting being conducted between the months of August 2023 and April 2024. During an interview, on 8/14/24 at 11:56 a.m., Social Service Director (SSD) indicated the care plan meetings were to be conducted annually and quarterly. The SSD was unable to provide documentation that Resident 24 care plan meetings were conducted on a quarterly basis and that she must have forgotten to document the care plan meeting in his chart. During an interview, on 8/15/24 at 10:20 a.m., the Administrator indicated they do not have documentation to show where the care plan meetings were conducted quarterly. She further indicated it was their company policy that the SSD would open an observation and complete the documentation in the computer system when the care plan meetings were conducted. On 8/14/24 at 12:13 p.m., the SSD provided a document, with a revised date of 8/23, titled, "IDT			

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	Comprehensive Care Plan Policy," and indicated it was the current policy being used by the facility. The policy indicated, " ...Resident, resident's representative, or others as designated by resident will be invited to care plan review. The care plan review may be conducted face to face, via phone conference, video conference, or through written communication per resident and or representative preference. Care plan problems, goals, and interventions must be reviewed and revised by the interdisciplinary team periodically and following completion of each MDS assessment ...." 3.1-35(e)			
F 0658 SS=D Bldg. 00	483.21(b)(3)(i) Services Provided Meet Professional Standards Based on interview and record review, the facility failed to ensure the Qualified Medication Aide (QMA) followed proper standards of practice for 1 of 1 residents reviewed for pressure ulcer care (Resident 218). Findings include: During an interview, on 8/12/24 at 9:29 a.m., Resident 218 indicated she had several open areas to her bottom, and they had been there since before her admission to the facility. She acquired the areas while living at home. During an interview, on 8/14/24 at 7:50 a.m., QMA 3 indicated Resident 218 was getting ready to take a shower and therefore she would not be doing the dressing change until after her shower. She further indicated the dressing changes would be completed by the wound Nurse Practitioner, the Assistant Director of Nursing, or other staff	F 0658	The resident observed was assessed for any negative effects with none noted. Residnet wound dressings are changed by licensed nurses. Other residents with wounds have the potential to be affected by the deficient practice. Education provided to all Nurse and QMAs regarding the scope of practice of a QMA and need for the nurse to complete the dressing change on wounds greater than a stage 1. DNS/Designee will complete rounds daily to ensure residents with wounds greater than stage 1 have dressings changed by licensed nurses. Emar will be reviewed by DNS/designee during AM meeting to ensure wounds are treated per protocol	09/13/2024

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	working the hall. During an interview, on 8/14/24 at 8:30 a.m., Resident 218 indicated QMA 3 had completed her pressure ulcer dressing changes before to her bottom. Resident 218's record was reviewed on 8/13/24 at 2:23 p.m. The profile indicated the resident diagnoses included, but were not limited to, type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar) and wedge compression fracture of T11-T12 vertebra (a type of vertebral compression fracture that occurs when the bone in the front of the spine column collapses and loses height resulting in a wedged shape). An admission minimum data set (MDS) assessment dated 8/12/24, indicated the resident was cognitively intact and had one stage 3 (full thickness tissue loss where subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed) pressure ulcer, two unstageable (when the stage is not clear due to the base of the wound being covered by a layer of dead tissue that may be yellow, grey, green, brown, or black) pressure ulcers, and three deep tissue injuries (purple or maroon area of discolored intact skin due to damage of underlying soft tissue from pressure and/or shear). A physician order, dated 8/5/24 with no end date, indicated to cleanse wounds to gluteal cleft, left and right gluteal folds with normal saline, apply skin prep to peri wound (the area of tissue surrounding a wound), apply medical grade honey (natural, non-toxic agent that can be used to treat wounds) to wound beds, cover with bordered foam, and change daily and as needed.		QAPI tool will be completed weekly times 4 weeks, monthly times 6 and then quarterly for 2 quarters. 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.	

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	A care plan, dated 8/5/24, indicated the resident had impaired skin integrity: Pressure injuries to gluteal cleft (a deep groove that runs between the buttocks from the sacrum to the perineum), right gluteal fold (a horizontal crease in the skin that separates the upper thigh from the buttocks), left gluteal fold, left heel, right heel, and left 5th toe related to wedge compression fracture of the thoracic vertebra, history of falls, and generalized weakness. Interventions included but were not limited to, assess wound weekly documenting measurements and description, float heels while in bed, and treat as ordered by physician. A skin and wound note, dated 8/7/24 at 9:01 a.m., indicated the following pressure wounds: a. An unstageable pressure ulcer to left gluteal fold. The wound measures 3 by (x) 2 cm (centimeters) with a depth of 0.1 cm. b. A stage 3 pressure ulcer to right gluteal fold. The wound measures 1.5 x 0.5 cm with a depth of 0.1cm. c. An unstageable pressure ulcer to coccyx. The wound measures 2 x 1.5 cm with a depth of 0.1 cm. During an observation, on 8/14/24 at 9:48 a.m., the Assistant Director of Nursing (ADON) removed an old dressing to Resident 218's left gluteal wound. The dressing had no date or staff initials on it. During an observation, on 8/14/24 at 9:56 a.m., the ADON removed an old dressing to the resident's coccyx and the dressing only contained a date of 8/13. There were no staff initials on the old dressing.			

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	During an observation, on 8/14/24 at 10:04 a.m., the ADON removed an old dressing to the resident's right gluteal fold and the dressing only contained a date of 8/13. There were no staff initials on the old dressing. During an interview, on 8/14/24 at 10:09 a.m., the ADON indicated nursing staff should place a date and their initials on the dressing when it was completed. Review of August 2024, Treatment Administration Record (TAR) indicated QMA 3 documented as completing the dressing changes to Resident 218's pressure wounds 4 out of 9 days. During an interview, on 8/14/24 at 10:52 a.m., Director of Nursing (DON) indicated QMAs were only allowed to do stage 1 dressing changes and anything over stage 1 must be completed by licensed nursing staff. During an interview, on 8/14/24 at 11:36 a.m., QMA 7 indicated she was allowed to do dressing changes on wounds that were a stage 1 or less. They were not allowed to do dressing changes on anything over a stage 1. During an interview, on 8/14/24 at 1:58 p.m., the DON indicated QMA 3 was questioned and the QMA thought she had accidently selected the complete all button when she was administering medications to Resident 218. The QMA indicated that explained how her initials got into the box as completing the dressing changes. The DON indicated when staff placed their initials in the documentation box that would be taken as they were the person who completed the treatment.			

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	On 8/14/24 at 1:55 p.m., the Administrator provided a document with a revised date of 07/23, titled, "Dressing Change Clean Technique," and indicated it was the current policy being used by the facility. The policy indicated, " ...date and initial new dressing ...." On 8/14/24 at 1:55 p.m., Administrator provided a document with a revised date of 07/24, titled, "QMA Parameters and Scope of Practice," and indicated it was the currently policy being used by the facility. The policy indicated, " ...At no time should a QMA ...8. Administer a treatment that involves an advanced skin condition, including Stage II, III, and IV pressure ulcers ...." 3.1-35(g)(1)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview, and record review, the facility failed to ensure medication storage areas were free from personal drinks, and failed to ensure expired medication was disposed of (Resident 38) for 2 of 4 medication carts reviewed for medication storage. Findings include: 1. During observation of medication storage and labeling on 8/15/24 at 10:58 a.m., in the bottom drawer of the A-hall medication cart, observed a plastic restaurant cup with a label on the outside indicating it to be iced coffee from 8/15/24. The drink was stored amongst residents medications. During an interview with Licensed Practical Nurse (LPN) 16 on 8/15/24 at 10:59 a.m., she indicated the drink belonged to her, and food or drink were not	F 0761	The resident was not given the eye drops. The drink was removed immediately and the cart sanitized. The outdated eye drops for resident 38 were destroyed. All residents on the halls had the potential to be affected. All Nurses and QMAs inserviced on appropriate medication storage practices. All medications carts were reviewed by DNS/Designee to ensure all medications were current and to ensure no food or drinks were stored in the cart DNS/Designee will observe carts each day to ensure medications are current and drawers are clean QAPI tool will be completed weekly times 4 weeks, monthly	09/13/2024

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	to be stored inside the medication carts. During an interview with the Administrator (ADM) on 8/16/24 at 9:57 a.m., she indicated staff were not supposed to have personal drinks in patient care areas, including the medication carts, and were supposed to keep them in the break room. 2. During an observation of medication storage and labeling on 8/15/24 at 11:19 a.m., in the top right drawer of the C-hall medication cart, observed latanoprost 0.005% eyedrops for Resident 38 with an opened date of 7/2/24. During an interview on 8/15/24 at 11:20 a.m., Licensed Practical Nurse (LPN) 10 indicated that she knew the eye drops were out of date, they were only good for six weeks after opening, and she had already ordered more. During an interview on 8/15/24 at 11:38 a.m., LPN 10 indicated she confirmed with the pharmacy that the eye drops were only good for six weeks after opening. They had been ordered, but the pharmacy did not get them delivered in time, they were on their way today. On 8/16/24 at 10:15 a.m. Resident 38's record was reviewed. Her diagnoses included, but were not limited to, acquired absence of eye (surgical removal of the eye), glaucoma (occurs when fluid builds up in the front part of the eye, increasing the pressure and causing damage to the optic nerve), and history of endophthalmitis (a serious infection of the fluid within the eye), A physician's order, dated 3/7/24, indicated to administer latanoprost 0.005% (medication used to decrease pressure in the eye) ophthalmic (eye),		times 6 and then quarterly for 2 quarters.. 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.	

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	one drop at bedtime. A medication administration record (MAR) for Resident 38 indicated that the latanoprost 0.005% ophthalmic was administered on 8/13/24, 8/14/24, and held on 8/15/24 due to the medication not being available, with a comment that indicated they were waiting on arrival from the pharmacy. During an interview with LPN 10 on 8/16/24 at 10:22 a.m., she indicated a new bottle of eyedrops was delivered, they used the new bottle last night and it was dated. The last day the eyedrops should have been used was 8/13/24. Anything documented as given after that should have been documented as giving expired medications until the new bottle arrived. On 8/15/24 at 11:55 a.m., the LPN 10 provided a document with a revision date of 6/30/23 and identified it as the current facility policy, titled, "Storage and Expiration Dating of Medications, Biologicals." The policy indicated, " ...3.5 The community should ensure food is not stored in the refrigerator, freezer or general storage areas where medications and biologicals are stored ...4. The community should ensure that medications and biologicals that ...(2) have been retained longer than recommended by manufacturer or supplier guidelines ...are stored separate from other medications until destroyed or returned to the pharmacy or supplier ...." 3.1-25(o)			