STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155542	A. BUILDING 00 B. WING	03/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVERLEAF OF KNIGHTSVILLE	9325 N CRAWFORD ST KNIGHTSVILLE, IN 47857

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F000000	This visit was for a recertification and state licensure survey. Survey Dates: March 23-28, 2014 Facility Number: 000296 Provider Number: 155542 AIM Number: 100467820 Survey Team: Laura Brashear, RN, TC Mary Weyls, RN Lora Brettnacher, RN, March 23-26, 2014 Census Bed Type: SNF/NF: 87 Total: 87 Census Payor Type: Medicare: 14 Medicaid: 47 Other: 26 Total: 87 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review completed 4/2/2014 by Brenda Marshall, RN.	F000000	This plan of correction is submitted as required by law. By submitting this plan of correction Cloverleaf Healthcare does not admit that the citations listed on the CMS 2567 exist nor does it admit to any statement, finding, facts or conclusion that forms the basis of alleged citations. Attached please find our plan of correction for our annual survey ending March 28, 2014. This plan of correction represents our written credible allegation of compliance. We respectfully request desk review of our plan of correction as we are in substantial compliance with all requirements of participation effective April 27, 2014. If you should have any questions please do not hesitate to contact me. Respectfully,	

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

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			Deanna Hickman HFA	
F000167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. Based on observation, interview, and record review, the facility failed to ensure posting of a sign to direct residents to the most recent survey results. This deficient practice had the potential to affect 87 of 87 residents who resided in the facility. Finding includes: On 3/28/14 at 1:55 p.m. a sign indicating location of the survey results, as well as the most recent survey report, was not observed. During an observation on 3/28/14 at 2:00 p.m., with the Administrator, the Administrator located the report amongst other books in a cabinet located the entrance to the facility. During interview of the Resident Council President on 3/28/14 at 1:30 p.m. Resident #2 indicated she was not sure where the survey results were located.	F000167	It is the policy of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice the following has been done:1.) Resident #2, Resident Council President was shown where the survey result book was located.2.) All residents have the potential to not know where the survey result book is located.3.) A framed sign is placed on cabinent to make Residents and Visitors aware of location of survey book. The location of the survey book was announced at Resident Council on 4/1/20144.) Administrator will audit that sign and survey results are noticeable and that Residents are aware of location	04/27/2014

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	Upon interview of the Administrator on 3/28/14 at 4:30 p.m. the Administrator indicated the sign which informed residents where to find the survey results had been removed.			
F000242 SS=D	3.1-(b)(1) 483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on record review and interview the facility failed to ensure the residents had the right to make choices concerning their care for 3 of 10 residents who met the criteria for choices, in that the facility failed to ensure resident preferences were honored in regard to showers and time for getting up in the morning for Residents #113, #89, and #25. Findings include: 1. During interview of Resident #113 on 3/23/14 at 1:20 p.m., the resident indicated her choice of shower frequency was not honored. She stated "No we don't choose, no one has asked me my preference. I get two [showers], if I were at home I would take one every day." The resident also indicated that she was not ask concerning her choice for getting up in the morning. The resident stated "They just turn the lights on and get us up.."	F000242	It is the policy of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice the following has been done:1.) Resident #113 stated that her wishes have changed and that she was content with the days of her shower schedule and she didn't wish to change her routine now. Resident stated she is an early riser and would like to be gotten up before breakfast. Resident # 89 has been discharged. Resident #25 has been interviewed and prefers to have one shower a week and total bed bath the rest of the days. This has been changed on the assigment sheet.2.) Using MDS 3.0 all Residents who have answered that making choices on how many bath/showers they took	

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	A CNA assignment sheet, provided by the DON on 3/28/13 at 11:25 a.m., included, but was not limited to, "Bathing Shower T [Tuesday]/F [Friday] Days." Resident #113's clinical record was reviewed on 3/28/14 at 2 p.m. An admission date was noted of 1/24/14. A Minimum Data Set (MDS) assessment dated 1/27/14 coded the resident with no cognitive impairment and it was very important to make choices of how many baths/showers she took a week. 2. During interview of Resident #89 on 3/23/14 at 1 p.m., the resident indicated that a choice was not provided concerning how many showers a week he would receive. Resident #89 stated "They tell me what to do, I think I take two or three a week." Resident #89's clinical record was reviewed on 3/28/14 at 2:15 p.m. An admission date of 3/7/14 was noted. An initial MDS assessment dated 3/11/14 coded the resident with severe cognitive impairment. The assessment coded the resident as very important in choosing how many times a week he received baths or showers. The CNA assignment sheet, provided by the DON on 3/28/14 at 11:25 a.m. indicated the resident received bathing/shower on Tuesday and Friday evenings. 3. Resident #25 was interviewed on 3/24/14 at 11:20 a.m. The resident indicated she wasn't asked her preference for shower days/frequencies. She indicated she		a week was very important had the potential to be at risk.3.) Upon admission all Residents or Residents families will be interviewed to determine what time and days showers would be accommodable to their normal routine. This will be added to the nrusing admission checklist. In addition Residents and Families will be asked at routine care plan meetings if their needs are being met regarding shower times. 4.) The DON or her designee is completing quality improvement audits of Resident Right to Make Choices. A random sample of 5 interviewable residents will be reviewed weekly for 30 days; then every other week for 30 days; then monthly for 6 months. Results of all audits are being discussed at the facility's QA Committee meeting monthly for additional recommendations if necessary.	

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	received showers on Wednesday and Saturday, but preferred showering once a week and washing up on other days. The resident's clinical record was reviewed on 3/24/14 at 11:48 a.m. The annual Minimum Data Set (MDS) assessment dated 8/14/13, coded the resident as cognitively intact. The assessment of the importance of choosing the type of bathing indicated it was somewhat important for the resident. The resident's functional ability indicated the resident required total dependence for bathing and was non-ambulatory. A care plan included, but was not limited to, shower two times weekly and bed bath five days weekly. Shower days are Wednesday and Saturdays. On 3/28/14 at 1:55 p.m., LPN #4 was interviewed. The nurse indicated showers were assigned based on the residents' room number. During interview of RN #5, on 3/28/14 at 10:40 a.m., the RN indicated she was the unit manager for Unit C. The RN indicated that new resident's shower days are assigned according to the room they are admitted to. During interview of the Activity Director on 3/28/14 at 10:50 a.m., the activities director indicated she interviewed the residents concerning activities and choices. The activities director indicated "I don't ask the residents concerning frequencies or preference of time of day for bathing." 3.1(u)(1)			

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F000312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review and interview the facility failed to ensure 1 of 3 residents reviewed for maintenance of personal hygiene, received the services in that Resident #13 was observed with facial hair. Finding includes: During observations on 3/25/14 at 10:30 a.m., and 3/28/14 at 9:10 a.m., Resident #13 was observed with several long white chin hairs. Resident 13's clinical record was reviewed on 3/28/14 at 2:32 p.m. A quarterly assessment, dated 1/13/14, indicated the resident required limited assist of one with personal hygiene. A plan of care dated 2/12/14, identified the resident with ADL (activities of daily living) self care performance deficit related to dementia and limited mobility impairment. During interview of CNA #1 on 3/28/14 at 3:10 p.m., the CNA indicated she assisted Resident #13 with her showers. The CNA indicated Resident #13 never refused care. The CNA indicated she had never attempted to remove the resident's facial hair and had not asked the resident if she would like the facial hair removed.	F000312	It is the practice of Cloverleaf of Knightsville to ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 1.) Resident #13 facial hair has been removed2.) Other residents have the potential to be at risk for this same practice.3.) All nursing staff have been inserviced and re educated on resident personal grooming and removing of unwanted facial hair. 4.)The DON or her designee is completing quality improvement audits of personal hygiene and grooming. A random sample of 5 residents will be reviewed weekly for 30 days; then every other week for 30 days; then monthly for 6 months. Results of all audits are being discussed at the facility's QA Committee meeting monthly for additional recommendations if necessary.	04/27/2014

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F000334 SS=E	3.1-38(a)(3)(D) 483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is			

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	medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. Based on interview and record review the facility failed to ensure flu vaccine information and/or consents for administration were provided to residents, family members, and/or legal representatives for 4 of 5 residents reviewed for flu vaccine administration (Residents #7, #79, #18, #48, and #83). This deficient practice had the potential to affect 57 of 87 residents residing in the facility during the flu season Findings include: 1. Resident #7's clinical record was reviewed on 3/24/14 at 1:55 p.m. An admission date	F000334	It is the practice of Cloverleaf of Knightsville to offer the influenza immunization to each resident and to include documentation in the medical record that the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and that the resident did or did not receive the influenza immunization due to medical contraindications or refusal.1.) Resident #7, #83, #79, recieved the flu vaccination and the documentation of the VIS being provided was pulled from	04/27/2014

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	was noted of 8/23/11. A signed flu and pneumo vaccination consent was signed in the fall of 2011, and on the record. Documentation of the VIS (Vaccination Information Statement) being provided was lacking from the consent. The resident received the flu vaccination on 10/18/13. A signed consent form and acknowledgement of receipt of the VIS was lacking. 2. Resident #18's clinical record was reviewed on 3/25/14 at 10:55 a.m. An admission date was noted of 8/12/11, with a signed flu and pneumo vaccine consent form dated 11/28/07. Documentation of the VIS being provided was lacking. The resident received a flu vaccine on 10/18/13. No consent or receipt of VIS being provided was noted. 3. Resident #83's clinical record was reviewed on 3/24/14 at 3:28 p.m. An admission date was noted of 6/16/12. A signed flu and pneumo vaccination consent for 2012 was noted. Acknowledgement of the receipt of the VIS was lacking. The resident received the flu vaccination on 10/18/13. A signed consent and acknowledgement of the VIS was lacking. 4. Resident #79's clinical record was reviewed on 3/25/14 at 10:55 a.m. An admission date was noted of 4/10/10. A signed flu and pneumo vaccination consent was on the chart dated 10/26/10. The consent did not include receipt of the VIS. The resident received the flu vaccination on 10/18/13. A signed consent and acknowledgement of receipt of the VIS was lacking. On 3/24/14 at 3:24 p.m. the Assistant		medical records and placed on residents chart. Resident # 18 consent and VIS was pulled from medical records and placed on Residents chart. 2.) Residents who were admitted prior to the flu season were at risk for the previous practice.3.) Our facility influenza and pnemococcal policy has been updated and revised to include that every year consents will be renewed and signed. Receipt of the VIS has also been added to the consent to confirm that the Resident or Residents responsible party has recieved this information. 4.)The DON or her designee is completing quality improvement audits during the flu season of renewal of vaccination consents and that Residents and or Responsible party has received the VIS. All new admissions will be checked through March 31st 2014 to ensure the clinical record includes documentation and updated consents. Results of the audits are being presented to the facility's QA Committee monthly for additional recommendations if necessary.	

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	Director of Nursing (ADON) was interviewed. The ADON indicated the business office annually sends out the Vaccination Information Statements to the residents' representatives. The ADON indicated acknowledgement of receipt of the information was not obtained or documented in the clinical records. The consent form titled "Influenza & Pneumococcal Immunization, Informed Consent" provided by the ADON on 325/14 at 9:38 a.m., did not include acknowledgement of being provided the VIS. The facility's policy titled "Influenza Vaccine," dated 11/01/2010, included but was not limited to: "The resident or responsible party will sign the consent form and give permission for vaccination annually while residing in the facility thus eliminating the need for repeated consent forms. The educational material will be provided annually. ...4. Prior to the vaccination, the resident (or resident's legal representative)...will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. (See current vaccine information statements at www.cdc.gov/nip/publications/VIS) for educational materials.) Provision of such education shall be documented in the resident's...medical record."			
F000356 SS=C	3.1-13(a) 483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date.			

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	o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to ensure the daily staff posting was in a prominent place readily accessible to residents and visitors. This had the potential to affect 87 of 87 residents of the facility. Finding includes: During observations on 3/28/14 at 1:40 p.m. with the Administrator present, the staffing information was observed posted 78 inches above floor level on a glass case located in	F000356	It is the policy of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice the following has been done:1.) The daily staffing data posting was moved to a more accessible location for all Residents2.) All Residents had the potential for the previous practice3.) The display case in which the daily staffing posting was located was moved to be visible by all Residents including those in	04/27/2014

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	the hallway adjacent to the building's entrance. It was not positioned for residents in wheelchairs to be able to read, and above eye level even when standing. The Administrator indicated it would not be readable by residents in wheelchairs. The facility's policy titled "Nursing Staffing Information Posting," dated 11/08/05, was provided by the Director of Nursing (DON) on 3/28/14. The policy included, but was not limited to, "3. The data will be posted in a clear and readable format. 4. Data will be posted in a prominent place readily accessible to residents and visitors."		wheelchairs.4.) Administrator will monitor weekly for 30 days and then quarterly thereafter and bring results to quarterly QA.	
F000371 SS=F	3.1-13(i)(4) 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and document review, the facility failed to properly store opened foods with labels, open dates, and/or expiration dates for 1 of 2 kitchen observations. Findings include: Observations of the facility's dry and cold food storage were made on 3/23/2014, beginning at 10:10 A.M. A container of opened worcestershire sauce had an expiration date of "February 2012." Dietary Aide #55 identified the contents of a Ziploc bag as "mozzarella cheese." The bag was	F000371	It is the practice of Cloverleaf of Knightsville to procure food from sources approved or considered satisfactory by Federal, State, or local authorities; and store, and prepare, distribute, and serve food under sanitary conditions. 1. All stored food was audited. Expired, undated or unlabeled items were discarded of.2. Residents were at risk of previous practice.3.). Food service personnel have been re-educated an inservice held on 4-17-2014 on how to properly store, label and date food . 4.)	

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	not marked with an open date or an expiration date. Dietary Aide #55 identified the contents of another Ziploc bag as "cheddar cheese." The bag was not marked with an open date or an expiration date. A bag of "shaved turkey" had an expiration date of 3/11/2014. Three pitchers containing liquid substances identified by the Dietary Manager [DM] as "ice tea, lemonade, and orange drink" were not dated. Ten bowls identified by the DM as chocolate pudding and "made yesterday" were not covered. Two containers stacked on top of each other filled with cups of "drinks for residents" were stored unlabeled and uncovered. During an interview on 3/23/2014 at 10:15 A.M., Dietary Aide #55 indicated all items should be labeled and dated with an open date and an expiration date. During an interview on 3/23/2014 at 10:30 A.M., the Dietary Manager indicated all items should be labeled and dated with an open date and an "use by date" and the expired food items should have been discarded. A facility policy provided by the DM on 3/25/2014 at 1:14 P.M., indicated, "...All foodstuffs [sic] are to be dated.... Label and date all food items... Juices... shall be stored in a tightly sealed, labeled, and date [sic] container... any opened products should be placed in seamless plastic or glass containers with tight-fitting lids. Label and date all storage containers....Left over storage... date container...." 3.1-21(i)(3)		The Food Service Manager or her designee is completing a quality improvement audit of storing, labeling and dating of food. Audits will be as followed: Three times weekly for 30 days; then weekly for 30 days; then monthly for 6 months. Results of all audits are being reviewed monthly by the facility's quality assurance committee for additional recommendations as necessary.	
F000458 SS=A	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155542	A. BUILDING 00 B. WING	03/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVERLEAF OF KNIGHTSVILLE	9325 N CRAWFORD ST KNIGHTSVILLE, IN 47857

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	Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. Based on observation, record review, and interview, the facility failed to provide at least 80 square feet (sq ft) per resident in a multiple resident room for 1 of 50 rooms in the facility (Room #14). Finding includes. Room #14 was observed on 3/23/14 at 11:30 a.m. and housed three residents. No concerns were observed as far as accommodation of needs. Room measurements provided by the Maintenance Supervisor on 3/28/14 at 2:00 p.m. and identified as unchanged from the previous measure date of 12/17/10 at 11:10 a.m., indicated resident room #14 had 3 beds in 225 square feet with 75 square foot per resident. On 3/28/14 at 2:00 p.m. the Administrator indicated she was aware the need for the room waiver. 3.1-19(l)(2)	F000458	It is the policy of this facility to ensure the hightest quality of care is afforded our residents. Consistent with this practice, the following has been done. SNF/NF Room 14, three resident bed, 225 square feet, equaled 75 sq feet per resident No other rooms are identified. A letter for room waiver was provided on 4/11/2014	04/27/2014