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	04/30/2019

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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00288435 and IN00288729. Complaint IN00288435 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00288729 - Substantiated. Federal/State deficiency related to the allegations is cited at F686. Survey dates: April 24, 25, 26, 29, and 30, 2019. Facility number: 000059 Provider number: 155697 AIM number: 100266560 Census Bed Type: SNF: 4 SN/NF: 62 Total: 66 Census Payor Type: Medicare: 6 Medicaid: 53 Private: 2 Other: 5 Total: 66 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 8, 2019.	F 0000		
F 0686 SS=G	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure			

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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Bldg. 00	Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.			
	Based on record review, observation, and interviews, the facility failed to ensure residents were provided the care and services, related to treatments and interventions, to prevent the development of an Unstageable Pressure Ulcer and a Deep Tissue Injury for 2 of 4 residents reviewed for pressure ulcers.(Residents B and C). Findings Include: 1. Review of the clinical record for Resident B on 04/26/19 at 09:55 a.m. The resident's diagnoses included, but were not limited to, acute transverse myelitis, stiffness of left knee and ankle, idiopathic progressive neuropathy, quadriplegia, and muscle weakness. The MDS (minimum data set) assessment, dated 3/12/19, indicated the resident was alert and oriented. The re-admission observation, dated 04/13/19, indicated the resident's skin was intact. The Physician's order, dated 4/17/19, indicated the resident's left heel DTI (Deep Tissue Injury) was	F 0686	Clark F-686 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ·Resident B has preventable measures in place to prevent skin breakdown-pressure reducing/redistribution cushion in chair, low air loss mattress, supplements, turn and reposition every 2 hours, pressure relief to left heel. ·Resident C 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	05/30/2019

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	to be cleansed with wound cleanser, patted dry, applied balsam-peru-castor oil ointment (a topical combination medicine used to promote healing and treat certain types of skin ulcers and wounds), and covered with an ABD (abdominal) pad daily and as needed for soilage or dislodgement. The resident's heels were to be floated while in bed and a pressure relief boot applied to the left foot at all times. The care plan, dated 10/18/2017 and last revised on 12/06/18, indicated the "Resident is at risk for skin breakdown... Resident will be free from skin breakdown... preventative treatment as ordered..." The care plan, dated 04/17/19, indicated the "Resident has impaired skin integrity: DTI Location: L Heel... treatment as ordered..." The "Initial Wound Review", dated 04/17/19 at 11:57 a.m., indicated "During skin sweeps resident noted to have DTI to L [left] Heel... DTI black with soft center Resident complains of pain with touch..." The "New Skin Event", dated 04/17/19 at 12:04 p.m., indicated the wound measured 2 cm in length and 4 cm in width. The review of the Treatment Administration Record, on 04/26/19 at 2:00 p.m., indicated the resident's treatment to the left heel had been documented as completed on both 04/24/2019 and 04/25/19. During an observation, on 04/25/19 at 9:04 a.m., the resident was observed lying in bed. The left heel was bandaged and lying directly on a pillow. The heel was not floated and the pressure relief boot was not in place.		deficient practice. ·Audit completed of all residents to ensure all who are at risk for skin breakdown have preventative interventions in place. ·Nursing staff in-serviced on preventative wound care per policy. ·Wound nurse/designee will validate treatments continue to be completed as ordered and pressure relieving devices are in place daily. ·Wound team to make weekly rounds on residents identified with skin impairment to ensure treatments continue to be completed per order, devices are in place for prevention of skin breakdown, notify Physicians as changes are needed and that the plan of care is current/up-dated as needed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? ·Nursing staff in-serviced on preventative wound care per policy. ·Wound nurse/designee will validate treatments continue to be completed as ordered and pressure relieving devices are in place. ·Wound team to make weekly rounds on residents identified with skin impairment to ensure treatments continue to be completed per order and devices	

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	During an observation, on 04/26/19 at 1:52 p.m., LPN (Licensed Practical Nurse) 6 removed the wound dressing from the resident's left heel. The dressing was dated 04/23/2019. There was an intact, dark black area, to the resident's heel measuring 2 cm in length and 3.7 cm in width. During an interview, on 04/25/19 at 9:05 a.m., the resident indicated she had a pressure sore on her heel. "They don't turn and reposition me. I can't do it at all myself." During an interview, on 04/29/19 at 2:08 p.m., the DON (Director of Nursing) indicated "Upon removing the dressing to the residents left foot, the bandage had a date of 4/23/2019. The treatment was daily and should have been changed on 4/24 and 4/25." During an interview, on 04/30/19 at 8:57 a.m. the DON indicated the resident's heels should be off loaded at all times and the pressure relief boot should always be in place. 2. Review of the clinical record for Resident C on 04/26/19 at 08:56 a.m. The resident's diagnoses included, but were not limited to, hemiplegia, hemiparesis, and muscle weakness. The admission MDS assessment, dated 01/14/19, indicated in Section M of the skin condition determination of pressure ulcer risk, Resident C had no unhealed pressure ulcer. The discharge MDS assessment, dated 02/7/19, indicated in Section M of the skin condition determination of pressure ulcer risk, Resident C had an unstagable pressure ulcer.		are in place for prevention of skin breakdown, notify Physicians as changes are needed and that the plan of care is current/up-dated as needed. ·DNS/designee will conduct rounds each shift to ensure preventative pressure relieving devices are in place per plan of care. 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 conduct rounds each shift to ensure preventative pressure relieving devices are in place per plan of care. ·To ensure compliance, the DNS/Designee is responsible for the completion of the skin management program CQI tool weekly for 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. Attachments A, B, C May 30, 2019 ·Facility requests IDR as we	

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	The care plan, dated 01/07/19 and revised on 01/24/19, indicated the "...Resident is at risk for skin breakdown due to: impaired mobility, moisture, DM [Diabetes Mellitus]... Resident will be free from skin breakdown... Encourage resident to turn and reposition at least every 2 hours; provide assistance as needed... House barrier cream at bedside - use as needed... Incontinent care as needed using peri wash and moisture barrier... Pressure reducing/redistribution mattress on bed..." A "temporary care plan" event, dated 01/24/19, indicated the resident had a new open area to the coccyx. A "non-pressure wound skin evaluation", dated 01/25/19, indicated the resident had an area of MASD (Moisture Associated Skin Damage) measuring 4 cm by 4 cm. A treatment of hydrogel and Optifoam was put into place. The Physician's order dated 01/25/19, indicated to cleanse the resident's coccyx with wound cleanser, pat dry, apply hydrogel, and cover with Optifoam Ag every day. The review of the Treatment Administration Record indicated the treatment had not been signed as completed on 01/29/19 or 01/30/19. A "New Skin" event, dated 02/06/19, indicated "Resident noted to have unstageable area to Coccyx. Area is open with yellow slough, wound bed not able to be visualized through slough. Wound edges are regular. Surrounding skin intact no drainage noted. Skin is warm to touch. Surrounding skin noted to have blanchable redness from MASD... Resident has noted decline since admission to facility. Incontinent of B&B		disagree with the severity assigned.	

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and not able to make needs known at all times. NP [Nurse Practitioner] notified of new skin area and monitoring with labs to monitor protein and albumin. Resident being followed weekly on NAR [Nutritionally at Risk]. New treatment orders placed in matrix will be followed weekly on wound rounds. Low-air-loss mattress ordered for wound healing. Resident to have side to side offloading q2h [every 2 hours] while in bed. All needs currently being met. Will continue to monitor."
The wound measured 4.5 cm in length, 4.2 cm in width, with an unable to be determined depth. The wound bed was yellow/red and the periwound was red.

A progress note, dated 02/06/2019 at 12:28 a.m., indicated the condition of the wound was "...much worse..." The wound was deeper and red.

During an interview, on 04/30/19 at 12:48 p.m., the DON indicated the treatment had not been signed out as completed on 01/29/19 and 01/30/19. There was no reason why they were not signed out and "they should have been completed and signed out".

The "Skin Management Program" policy, dated 03/2010 and last revised 04/2018, was provided on 04/30/19 at 11:15 a.m. "It is the policy of [Name of Corporation] to ensure that each resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individuals clinical condition demonstrated that they were unavoidable; and a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing... Deep Tissue Injury... This injury results from intense

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	and/or prolonged pressure and shear forces at the bone muscle interface... 3. Interventions to prevent wounds from developing and/or promote healing will be initiated based upon the individual's risk factors to include but not limited to the following... Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.)... This Federal tag relates to complaint IN00288729. 3.1-40			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services			

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	to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on record review, observation, and interviews, the facility failed to ensure thorough cleaning of the catheter tubing was completed during catheter care for 1 of 2 resident's observed for catheter care. (Resident B) Findings include: During the review of the clinical record, on 04/26/19 at 09:55 a.m., Resident B's diagnoses included but were not limited to, urinary tract infection, personal history of urinary calculi, pseudomonas, and neuromuscular dysfunction of bladder. The review of the resident's care plan, dated 03/07/2019, indicated the "Resident requires an indwelling urinary catheter due to: urine retention following kidney stone sx [surgery]... Resident will have catheter care managed appropriately as evidenced by: not exhibiting signs of urinary tract infection or urethral trauma.... Provide assistance for catheter care... Report signs of UTI [Urinary Tract Infection] (acute confusion, urgency, frequency, bladder spasms, nocturia, burning, pain/difficulty urinating, nausea, emesis, chills, fever, low back/flank pain, malaise, foul odor, concentrated urine, blood in urine)..." The current physician's order for Resident B	F 0690	Clark F-690 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ·Resident B did not have a negative outcome related to the alleged deficient practice. Catheter care is provided on each shift per physician order. 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 other residents with catheters were reviewed by the DNS/Designee and they receive catheter care per physician order. ·Nursing staff have been in-serviced on Indwelling Urinary Catheter Care, Emptying Drainage Bag & Catheter removal policy and procedure. ·Catheter Care skills validation	05/30/2019

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	indicated the resident was to receive catheter care every shift. During an interview, on 04/04/19 at 01:00 p.m., CNA 5 indicated she had already completed catheter care for the resident. The DON (Director of Nursing) had requested the CNA to complete the task again. During an observation of catheter care for the resident, on 04/26/19 at 01:13 p.m., CNA 5 removed the resident's sheet and brief, exposing the catheter. A strong odor of urine and a buildup of brown substance encrusted the first 4 inches of the catheter tubing from the urethra towards the drainage bag. CNA 5 proceeded to cleanse the catheter, by holding the catheter with her left hand and with her right hand using wipes in a downward motion from the urethra. During an interview, on 04/25/19 at 09:00 a.m., the resident indicated, "They don't clean it like they should. Definitely not once a day..." During an interview, on 04/29/19 at 01:54 p.m., CNA 5 indicated, she had completed catheter care approximately an hour and a half prior to the observation of catheter care on 04/26/19. The resident sometimes had discharge which stuck to the catheter tubing. "Sometimes it [brown substance] just sticks to it and even when you clean it still just sticks. Her skin seems to stick to it sometimes... when I can't get it I generally ask the nurse if she can get it or they have to change it." During an interview, on 04/29/19 at 02:04 p.m., the DON indicated "No one's reported buildup recently. They should clean it as much as possible. If it's something that's stuck on there		has been completed on all nursing staff. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? ·Nursing staff have been in-serviced on Indwelling Urinary Catheter Care, Emptying Drainage Bag & Catheter removal policy and procedure. ·Catheter Care skills validation has been completed on all nursing staff. ·DNS/Designee will audit catheter care daily on each shift for 4 weeks, then bi-weekly for 2 months, then weekly 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 audit catheter care daily on each shift for 4 weeks, then bi-weekly for 2 months, then weekly for 6 months. ·To ensure compliance, the DNS/Designee is responsible for the completion of the catheter-CQI tool weekly for 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive	

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	over and over and cannot be gotten off most likely it needs to be replaced. We've replaced it a couple of times. If it's still crusty we just may need to go ahead and replace it." The "Indwelling Urinary Catheter Care, Emptying Drainage Bag & Catheter removal" policy and procedure, dated 01/2010, last revised 12/2012, which the DON provided on 04/30/2019 at 11:15 a.m., indicated "6. Using the non-dominant hand grasp the catheter tubing where it enters the meatus. 7. Using the dominant hand retrieve a wet soaped washcloth, cleanse the catheter in circular motion for about 10 cm (4 inches). Start cleansing where the catheter enters the meatus and down toward the drainage tube." 3.1-18(a)		quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. Attachments D, E, F May 30, 2019	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;			

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	§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review, observation, and interview, the facility failed to ensure enteral nutrition was administered as ordered by the physician for 1 of 1 residents reviewed for enteral nutrition. (Resident 26). Findings include: During the review of the clinical record, on 04/26/19 at 08:12 a.m., Resident 26's diagnoses included, but were not limited to, mild protein calorie malnutrition, dysphagia, and gastrostomy status. The review of the care plan, dated 04/16/19, indicated the "Resident requires enteral nutrition to meet nutrient needs... Diet as ordered: NPO [Nothing per Oral], enteral nutrition... Provide enteral feeding per MD order..." The review of the physician's order, dated 11/02/19, indicated the resident;s enteral feeding was to be flushed with 135 mL of water every four hours 12:00 a.m., 4:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. The review of the physician's order, dated 11/09/19 to 04/09/19, indicated the resident's enteral feeding was Osmolite (complete nutrition formula) 1.5 at 55 mL/hr (milliliters per hours) every shift at 7:00 p.m. to 7:00 a.m. and 7:00 a.m. to 7:00 p.m. The review of the physician's order, dated 04/09/19 to 04/10/19, indicated the resident's enteral feeding was Two Cal every shift until osmolite arrives.	F 0692	Clark F-692 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ·Resident 26 did not have a negative outcome related to the alleged deficient practice. The resident currently receives enteral nutrition and medication per physician order and per enteral therapy policy. 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 other residents receiving enteral therapy were reviewed by the DNS/Designee and they receive enteral nutrition and medication per physician order and per enteral therapy policy. ·Licensed nursing staff have been in-serviced on the enteral therapy policy and procedure. ·Enteral Tube Procedure and Enteral Nutrition skills validation has been completed on all licensed nursing staff. What measures will be put into place or what systemic changes	05/30/2019

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(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
	The review of the physician's order, dated 04/11/19, indicated the resident's enteral feeding was Osmolite 1.5 at 55 mL/hr (milliliters per hours) continuous. The progress note, dated 02/28/2019 at 02:42 p.m., indicated "Continues feeding 135 ml/hr per G-Tube [gastrostomy tube] and flush every 2 hrs per pump settings..." The progress note, dated 02/26/2019 at 10:36 a.m., indicated "Continues feeding 135 ml/hr per G-Tube and flush every 2 hrs." During an observation, on 04/29/19 at 02:40 p.m., the resident was lying in bed with the head of the bed elevated. The gastrostomy pump was connected to the resident and running at a rate of 135 mL/hr with 150 mL of water to be flushed every 4 hours. The resident had no signs of an adverse reactions during the observation. During an interview, on 04/29/19 at 02:44 p.m., the DON indicated, "The feeding is supposed to be 55 mL/hr and the flush was 135 mL every 4 hours. It was not set on the correct rate." During an interview, on 04/29/19 at 02:46 p.m., LPN 4 indicated "Earlier when we changed it, I thought I had it correct... We reset the settings. We looked at the order in the computer, I thought I did it correctly but maybe I did it backwards." During an observation, on 04/29/19 at 12:47 p.m., after the administration of medication via g-tube for Resident 26, LPN (Licensed Practical Nurse) 4 started the Osmolite feeding per g-tube at a rate of 135 ml/hour. She also started the water flush at a rate of 150. She did not check for placement prior to medication or feeding administration.		will be made to ensure that the deficient practice does not recur? ·Licensed nursing staff have been in-serviced on the enteral therapy policy and procedure. ·Enteral Tube Procedure and Enteral Nutrition skills validation has been completed on all licensed nursing staff. ·DNS/Designee will audit enteral nutrition daily on each shift for 4 weeks, then bi-weekly for 2 months, then weekly 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 audit enteral nutrition daily on each shift for 4 weeks, then bi-weekly for 2 months, then weekly for 6 months. ·To ensure compliance, the DNS/Designee is responsible for the completion of the Enteral Nutrition-CQI tool weekly for 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	04/30/2019

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	During an interview on 04/30/19 at 9:43 a.m., the RD (Registered Dietician) indicated she would consider 100 ml/hour to be the most she would recommend. GI (gastro-intestinal) intolerance of some sort could be caused if the rate was above that. "We would have to monitor for nausea, vomiting, diarrhea on the resident." The 135 ml flush every 4 hours would be correct. The review on 04/30/19 at 11:15 a.m., of the Enteral Therapy policy, revised 01/2016, included, but was not limited to, "...A licensed nurse will take, note, and implement physician orders for enteral therapy...The following orders should be obtained when enteral therapy is being implemented or changed...Flow rate or cyclic schedule. Amount and frequency of water flushes including medication administration flushes....Placement verification frequency...Placement of the enteral therapy tube...is to be assessed by the licensed nurse no less than once every shift and before any substance is administered through the tube..." 3.1-46(a)(1)		Attachments G, H, I, J, K May 30, 2019	