| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155295 | A. Building<br>B. Wing | 08/15/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Clinton House Rehabilitation and Healthcare Center | 809 W Freeman St<br>Frankfort, IN 46041 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.<br><br>Based on interview and record review, the facility failed to ensure a comprehensive Minimum Data Set (MDS) assessment was completed within 14 days of admission for 1 of 4 residents reviewed for MDS assessments. (Resident 12)Finding includes:The clinical record for Resident 12 was reviewed on 8/11/25 at 2:42 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), dementia, and congestive heart failure.Resident 12 had an entry MDS assessment completed on 6/30/25.An admission MDS assessment, with an Assessment Reference Date (ARD) date of 7/13/25, was still in progress and was not completed as of 8/12/25.During an interview, on 8/12/25 at 2:42 p.m., the MDS Coordinator indicated the admission comprehensive MDS assessment was overdue by 30 days. The assessment should have been completed by 7/13/25.During an interview, on 8/12/25 at 2:45 p.m., the MDS Coordinator indicated the facility followed the Resident Assessment Instrument (RAI) manual for their policy.An RAI manual, titled Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.19.1, effective October 1, 2024, indicated .When admitting a resident from another nursing home, regardless of whether or not it is a transfer within the same chain, a new admission assessment must be done within 14 days.By statute, the RAI must be completed within 14 days of admission. As an integral part of the RAI, CAAs must be completed and documented within the same time frame.3.1-31(d)(1) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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| F 0638<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assure that each resident?s assessment is updated at least once every 3 months.<br><br>Based on interview and record review, the facility failed to ensure quarterly Minimum Data Set (MDS) assessments were completed every 3 months for 3 of 4 residents reviewed for MDS assessments. (Resident 17, 30, and 59)Findings include:1. The clinical record for Resident 17 was reviewed on 8/11/25 at 3:15 p.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, type 2 diabetes mellitus, moderate vascular dementia with psychotic and mood disturbance, and anxiety disorder.The first quarterly assessment after the annual comprehensive Minimum Data Set (MDS) assessment for Resident 17 was completed on 4/6/25. The next quarterly assessment was completed 4 months later (127 days), on 8/11/25.2. The clinical record for Resident 30 was reviewed on 8/11/25 at 3:20 p.m. The diagnoses included, but were not limited to, hydrocephalus, paraplegia, and mild dementia with mood disturbance.The first quarterly assessment after the annual comprehensive Minimum Data Set (MDS) assessment for Resident 30 was completed on 4/8/25. The next quarterly assessment was completed 4 months later (122 days), on 8/8/25.3. The clinical record for Resident 59 was reviewed on 8/11/25 at 3:35 p.m. The diagnoses included, but were not limited to, autistic disorder and epilepsy without status epilepticus.The first quarterly assessment after the annual comprehensive Minimum Data Set (MDS) assessment for Resident 30 was completed on 4/10/25. The next quarterly assessment was completed over 3 months later (120 days), on 8/8/25.During an interview, on 8/12/25 at 2:45 p.m., the MDS Coordinator indicated the facility followed the Resident Assessment Instrument (RAI) manual for their policy. The quarterly assessment should have been completed within 3 months according to the manual.An RAI manual, titled Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.19.1, effective October 1, 2024, indicated the Assessment Reference Date (ARD) is no later than the ARD of the previous OBRA assessment of any type + 92 calendar days. The MDS Completion Date of the Quarterly Assessment must be no later than 14 days after the ARD (106 days). 3.1-31(d)(3) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>Based on interview and record review, the facility failed to ensure the physician was notified of high blood glucose levels within the physician's ordered call parameters for 1 of 1 resident reviewed for quality of care. (Resident 53)Findings include: The clinical record for Resident 53 was reviewed on 8/11/25 at 2:00 p.m. The diagnoses included, but were not limited to, morbid obesity, type 2 diabetes, and hypertension.A physician's order, dated 7/22/25, indicated to give Admelog injection (insulin lispro) per sliding scale. If the blood glucose was 401 or more, give 9 units and call the Medical Doctor (MD).The following blood glucose readings were over 401 with no documentation the MD was called:a. On 7/23/25 at 11:29 a.m., the blood glucose reading was 496 with no documentation the MD was called.b. On 7/31/25 at 4:40 p.m., the blood glucose reading was 401 with no documentation the MD was called.c. On 8/6/25 at 9:18 p.m., the blood glucose reading was 417 with no documentation the MD was called.d. On 8/7/25 at 8:43 p.m., the blood glucose reading was 416 with no documentation the MD was called. During an interview, on 8/12/25 at 2:09 p.m., the Director of Nursing (DON) indicated notification to the physician would be scanned into the miscellaneous tab in the electronic record and would be documented in the notes.During an interview, on 8/12/25 at 2:14 p.m., the DON indicated notification could also be attached to the order and would show up in the administration record. She would look for those dates to see if there was notification. During an interview, on 8/12/25 at 2:36 p.m., the DON indicated she could not locate documentation of the notifications for the high blood glucose readings in the record.During an interview, on 8/15/25 at 10:30 a.m., Licensed Practical Nurse (LPN) 4 indicated the MD should have been notified if there were call orders and the notification should have been documented in the resident's record.A current facility policy, titled Notification of Resident's Change in Condition, with an effective date of 9/11/23 and received from the DON on 8/15/25 at 8:44 a.m., indicated .The nurse will notify the resident's attending physician or physician on call when there has been a(an).Specific instruction to notify the physician of changes in the resident's condition.3.1-37(a) |

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| F 0727<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.<br><br>Based on interview and record review, the facility failed to ensure a Registered Nurse (RN) was scheduled for at least 8 consecutive hours 7 days a week for 2 of 21 days reviewed for staffing. (7/20/25 and 8/3/25)Findings include:The as worked staffing schedules were reviewed on 8/11/25 at 1:35 p.m. A RN was not scheduled to work on Sunday, 7/20/25. A RN was not scheduled to work on Sunday, 8/3/25. The facility assessment, dated 3/17/25, indicated the facility had 2 residents who required IV (Intravenous) medications on average. Staff with specialized training such as RNs were to be assigned to areas with residents with higher acuity needs.During an interview, on 8/15/25 at 10:19 a.m., the Director of Nursing indicated there was no RN present in the facility on 7/20/25 and 8/3/25. The facility followed the CMS guidelines for staffing, and an RN should have been present on those dates for at least 8 consecutive hours.The facility did not provide a staffing policy prior to exit.<br>3.1-17(b)(3) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation, interview and record review, the facility failed to ensure PPE (personal protective equipment) was worn correctly and to establish a clean field for wound care supplies for 1 of 6 residents reviewed for infection control. (Resident 21)Finding includes:During an observation, on 8/14/25 at 9:32 a.m., Unit Manager (UM) 2 gathered wound care supplies, which included, an antiseptic wound cleanser, gauze pads, calcium alginate with silver (an antimicrobial dressing), and a foam bordered dressing, in preparation to perform a wound care treatment for Resident 21. After gathering the wound care supplies, UM 2 then put on PPE (a gown and gloves). UM 2 did not tie the gown closed around her waist. UM 2 then placed the wound care supplies on Resident 21's bedside table and opened them. UM 2 was not observed to have cleaned the surface of the bedside table prior to placing the wound care supplies on the table and opening them. The wound care supplies were observed to have been placed on the bedside table next to a urinal with approximately 200 milliliters of urine in it. After completing the wound care treatment, UM 2 placed the bedside table within Resident 21's reach and asked Resident 21 if he would like her to empty the urinal before leaving the room.During an interview, on 8/14/25 at 9:43 a.m., UM 2 indicated she was not aware the gown had ties for the waist section, and the gown should have been tied around the waist. UM 2 also indicated the urinal should have been removed from the bedside table prior to performing the wound care treatment.The clinical record for Resident 21 was reviewed on 8/14/25 at 3:04 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus, rhabdomyolysis, and cognitive communication deficit.A physician's order, dated 8/5/25, indicated Resident 21 required the use of enhanced barrier precautions (EBP) with a sign posted to communicate to staff to ensure a gown and gloves were used during identified high contact care activities.During an interview, on 8/14/25 at 11:40 a.m., the Director of Nursing (DON) indicated UM 2 emptied the urinal prior to the wound care treatment. The DON indicated UM 2 said after she put on her gown and gloves, she noticed the urinal had been used again and she did not want to change gloves again, so UM 2 offered to empty the urinal after the treatment. If the gown had ties around the waist, the gown should have been tied.A current facility policy, titled Clean Dry Dressing Change, dated 8/1/23 and received from the DON on 8/14/25 at 12:00 p.m., indicated .Review the resident's care plan, current orders, and diagnoses to determine if there are special resident needs.The following equipment and supplies will be necessary when performing this procedure.Personal protective equipment [(e.g., gowns, gloves.)].Clean bedside stand. Establish a clean field.Place the clean equipment on the clean field.A current facility policy, titled Enhanced Barrier Precautions, dated 11/1/23 and received from the DON on 8/14/25 at 12:00 p.m., indicated .It is the policy of the facility to ensure that Enhanced Barrier Precautions [(EBPs)] are utilized to prevent the spread of multi-drug resistant organisms [(MDROs)] to residents.Enhanced barrier precautions [(EBPs)] are used as an infection prevention and control intervention to reduce the spread of multi=drug resistant organisms.to residents.3.1-18(b) |

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| F 0732<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>Based on interview and record review, the facility failed to ensure the daily nurse staffing data was posted at the beginning of each shift on 1 of 6 survey observation dates. (8/10/25)Findings include:During an observation, on 8/10/25 at 12:21 p.m., the posted nurse staffing data sheet was dated for 8/8/25.During an interview, on 8/11/25 at 12:55 p.m., the Director of Nursing (DON) indicated the scheduler created the daily nurse staffing data forms and posted it each morning. On the weekends, she created it ahead of time, and the manager on duty was supposed to post it each morning. The Saturday and Sunday sheets were placed in the posting frame behind Friday's sheet to be pulled forward over the weekend. If there were call-ins or changes, it would not reflect those on the weekend or night shifts after she went home. The staffing should be posted each morning, even during the weekend. If the posted sheet was dated 8/8/25, then the nurse staffing data sheet for 8/9/25 must not have been pulled forward on Saturday and Sunday's sheet was not pulled forward at the beginning of the shift.The facility did not provide a policy on nurse staffing data posting prior to exit.3.1-17(a) |