

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155542	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER Cloverleaf of Knightsville		STREET ADDRESS, CITY, STATE, ZIP CODE 9325 N Crawford St Knightsville, IN 47857	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>35317</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure residents were addressed in a dignified manner and the facility failed to ensure a resident was assisted during meal service in a dignified manner for 2 of 3 dining observations. (Residents 56 and 31).</p> <p>Findings include:</p> <p>1. During the lunch meal observation in the activity dining room, on 12/12/24 at 12:41 p.m., Resident 56 was sitting at a table eating her lunch when CNA 5 addressed the resident as Honey. CNA 5 stated from the opposite table, Honey use your silverware to Resident 56.</p> <p>Resident 56's record was reviewed, on 12/16/24 at 1:48 p.m. The profile indicated the resident's diagnosis included, but were not limited to, unspecified dementia, severe, with anxiety (a person who is experiencing a significant level of cognitive decline where the exact type of dementia is not known, and alongside this cognitive impairment, they are also exhibiting symptoms of anxiety) and cerebral infarction affecting right dominant side (a stroke (cerebral infarction) has occurred in the right hemisphere of the brain, which is considered the dominant side for most people causing symptoms like weakness or paralysis on the left side of the body).</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 11/26/24, indicated the resident had severe cognitive impairment and was independent with eating.</p> <p>A care plan, dated 5/15/24, indicated the resident had personal preferences in regards to her care based on her personal preferences assessment. Interventions included, but were not limited to, call me by my first name. The record lacked a care plan indicating resident preferred to be called, Honey.</p> <p>2. During the lunch meal observation on the rehab unit, on 12/16/24 at 1:17 p.m., CNA 5 was standing up next to Resident 31 assisting her with lunch meal. CNA 5 continued to assist with feeding the resident while standing next her. CNA 5 addressed Resident 31 as Honey. She asked Resident 31, How are you doing Honey? She proceeded to feed the resident and asked, Sweet girl, are you hungry?</p> <p>(continued on next page)</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155542	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER Cloverleaf of Knightsville		STREET ADDRESS, CITY, STATE, ZIP CODE 9325 N Crawford St Knightsville, IN 47857	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 31's record was reviewed, on 12/16/24 at 2:01 p.m. The profile indicated the resident's diagnosis included, but were not limited to, unspecified dementia (a person who is experiencing a significant level of cognitive decline where the exact type of dementia is not known) and syndromes with complex partial seizures (most common type of seizures in adults, they can last between 30 seconds and 2 minutes). The record lacked a care plan indicating resident preferred to be called, Honey or Sweet girl.</p> <p>An annual Minimum Data Set (MDS) assessment, dated 10/1/24, indicated the resident had severe cognitive impairment and was a maximum assist with eating.</p> <p>During an interview, on 12/16/24 at 1:27 p.m., the Director of Nursing (DON) indicated staff should not stand up next to a resident to assist with feeding. The staff should sit next to the resident while assisting with a meal. She further indicated staff should address residents by their preferred name. She would do some training with staff on making sure to address residents by their preferred name and in a dignified manner.</p> <p>On 12/16/24 at 1:53 p.m., the Administrator provided a document with a revised date of July 2017, titled, Assistance with Meals, and indicated it was the policy currently being used by the facility. The policy indicated, .Residents shall receive assistance with meals in a manner that meets the individual needs of each resident .3. Residents who cannot feel themselves will be fed with attention to safety, comfort, dignity, for example: a. Not standing over residents' while assisting them with meals</p> <p>On 12/16/24 at 1:53 p.m., the Administrator provided a document with a revised date of January 2019, titled, Resident Rights, and indicated it was the policy currently being used by the facility. The policy indicated, .1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights included resident's right to: a. a dignified existence b. be treated with respect, kindness, and dignity</p> <p>3.1-3(a)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155542	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER Cloverleaf of Knightsville		STREET ADDRESS, CITY, STATE, ZIP CODE 9325 N Crawford St Knightsville, IN 47857	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>35317</p> <p>Based on interview and record review, the facility failed to monitor a resident's weight as ordered for 1 of 4 reviewed for nutrition (Resident 59).</p> <p>Finding includes:</p> <p>During an interview, on 12/12/24 at 11:14 a.m., Resident 59 indicated he had some weight loss when he first came to the facility, but he thought his weight had stabilized now.</p> <p>Resident 59's record was reviewed on 12/17/24 at 10:18 a.m. The profile indicated the resident's diagnosis included, but were not limited to, chronic kidney disease, stage 3 (a person has moderate damage to their kidneys where they are not filtering waste effectively, resulting in mild to moderate loss of kidney function), prediabetes (you have a higher-than-normal blood sugar), and repeated falls.</p> <p>An admission Minimum Data Set (MDS) assessment, dated 11/22/24, indicated the resident was cognitively intact and had an admission weight of 210 pounds.</p> <p>A care plan, dated 11/20/24, indicated the resident was at risk for nutritional deficits related to chronic kidney disease stage 3 and prediabetes. Interventions included, but were not limited to, weights as directed and observe and report to MD (medical doctor) for signs and symptoms of malnutrition.</p> <p>A physician order, dated 11/20/24, to obtain a weight daily for 3 days then weekly times 4 weeks.</p> <p>Review of Resident 59's weights in the electronic health record indicated the following:</p> <ul style="list-style-type: none"> a. dated 11/20/24 at 2:44 p.m. - 208.5 pounds and documentation was struck out in error on 11/25/24 by nurse. b. dated 11/20/24 at 2:51 p.m. - 210 pounds and documentation was struck out in error on 11/25/25 by nurse. c. dated 11/25/24 at 11:55 a.m. - 197 pounds d. dated 12/4/24 at 12:36 p.m. - 201.6 pounds e. dated 12/11/24 at 4:28 p.m. - 196 pounds f. dated 12/16/24 at 1:50 p.m. - 199 pounds <p>The record lacked documentation of a weight being obtained until 11/25/24.</p> <p>Review of an admission evaluation, dated 11/19/24 at 5:37 p.m., the record lacked documentation of a weight for Resident 59 was recorded.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155542	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER Cloverleaf of Knightsville		STREET ADDRESS, CITY, STATE, ZIP CODE 9325 N Crawford St Knightsville, IN 47857	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Treatment Administration Record (TAR) for November 2024 lacked documentation of a daily weight being completed on 11/21/24 and 11/22/24. The record lacked documentation of a resident's refusal to obtain his weight.</p> <p>Review of a care plan note, dated 11/25/24 at 12:23 p.m., indicated Resident's current weight was 210 pounds and on a regular diet.</p> <p>During an interview, on 12/17/24 at 11:54 a.m., the Director of Nursing (DON) indicated she could not find where Resident 59 had daily weights completed per the physician order in his electronic health record. Daily weights for 3 days and the weekly for 4 weeks was a standard order that would be placed in the electronic health record for new admissions.</p> <p>Review of a paper report sheet, dated 11/19/24, was provided by the DON and indicated it had a weight of 198.7 pounds for Resident 59. The DON indicated the weight was not placed in the electronic health record at the time of admission by the nurse and the DON placed it in the record on 12/17/24.</p> <p>On 12/17/24 at 12:57 p.m., the Administrator provided a document with a revised date of March 2019, titled, Weight Assessment and Intervention, and indicated it was the policy currently being used by the facility. The policy indicated, .1. The nursing staff will measure weight on admission .2. Weights will be recorded in each individual's medical record .3. If a resident declines to participate in a weight loss goal or weights being obtained, the resident's wishes will be documented, and those wishes will be respected</p> <p>3.1-37</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155542	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER Cloverleaf of Knightsville		STREET ADDRESS, CITY, STATE, ZIP CODE 9325 N Crawford St Knightsville, IN 47857	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>34525</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident's indwelling urinary catheter (a thin, flexible tube that is inserted into the bladder through the urethra to drain urine), drainage bag and tubing were maintained in a manner to prevent contact with the floor for 1 of 2 residents reviewed for urinary catheters (Resident 1).</p> <p>Findings include:</p> <p>During the initial pool observation, on 12/13/24 at 8:50 a.m., Resident 1 was observed in her bed and the bed was in the low position. Her indwelling urinary catheter drainage bag (catheter bag) was observed in contact with the floor. At the same time, the catheter's tubing was observed sitting on the electrical cord for the resident's oxygen concentrator (a medical device that supplies oxygen-enriched air by removing nitrogen from the air around the patient). The electrical cord was observed in contact with the floor.</p> <p>During a random observation, on 12/13/24 at 3:10 p.m., the resident was observed in her bed. The bed was observed in the low position. The resident's catheter bag was observed to be in contact with the floor.</p> <p>During a random observation, on 12/16/24 at 1:10 p.m., the resident was observed in her bed in the hallway outside of her room due to a temporary power outage. Her bed was in the low position. The resident's catheter bag was observed to be in contact with the floor.</p> <p>During a random observation, on 12/16/24 at 1:53 p.m., the resident was observed in her bed which had been moved back into her room. Her bed was in the low position. The resident's catheter bag was observed to be in contact with the floor.</p> <p>Resident 1's record was reviewed on 12/16/24 at 2:10 p.m. The profile indicated the resident's diagnoses included, but were not limited to, stage 3 chronic kidney disease (mild to moderate damage to the kidneys where they are less able to filter waste and fluid out of the blood), stage 4 pressure ulcer to sacral region (a very severe wound on the skin over the tailbone area where the damage extends through all layers of skin, potentially exposing muscle, bone, and tendons), and muscle wasting an atrophy (the loss of muscle tissue and strength).</p> <p>A significant change Minimum Data Set (MDS) assessment, dated 10/18/24, indicated the resident had severe cognitive deficit, had an indwelling urinary catheter, and received hospice services.</p> <p>A care plan, dated 10/17/24, indicated the resident had a Foley (brand name) catheter related to wounds. The interventions lacked documentation of monitoring the catheter bag or tubing from coming in contact with the floor.</p> <p>A physician's order, dated 10/17/24, indicated that the resident have a 16 French (Fr) (size of a catheter described in French units) catheter.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155542	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER Cloverleaf of Knightsville		STREET ADDRESS, CITY, STATE, ZIP CODE 9325 N Crawford St Knightsville, IN 47857	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A physician's order, dated 10/17/24, indicated for staff to perform catheter care (a set of practices that help prevent infection and maintain the health of a catheter and the surrounding area) every shift two times a day.</p> <p>During an interview, on 12/16/24 at 2:41 p.m., the Director of Nursing (DON) indicated the resident's catheter bag was likely in contact with the floor due to her bed being in the low position. Catheter bags and tubing should never come in contact with the floor.</p> <p>On 12/16/24 at 3:01 p.m., the Administrator (ADM) provided a document, with a revised date of September 2014, titled, Catheter Care, Urinary, and indicated it was the policy currently being used by the facility. The policy indicated, .Infection Control .2.b. Be sure catheter tubing and drainage bag are kept off the floor</p> <p>3.1-41(a)(2)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155542	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER Cloverleaf of Knightsville		STREET ADDRESS, CITY, STATE, ZIP CODE 9325 N Crawford St Knightsville, IN 47857	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48226</p> <p>Based on observation, record review and interview the facility failed to assess a resident's condition for complications before and after hemodialysis treatments (a procedure that removes waste products and excess fluid from the blood when the kidneys are no longer functioning properly) which were received at a certified dialysis facility for 1 of 2 residents reviewed for dialysis (Resident 49).</p> <p>Findings include:</p> <p>On 12/12/24 at 11:34 a.m., during observation and interview, Resident 49 indicated when she received hemodialysis on Monday, Wednesday, and Friday. The staff did not check the access site (also known as vascular access, a surgically created opening in the body that allows a patient to receive hemodialysis) in her left arm after returning from dialysis treatment. She indicated when she returned yesterday 12/11/24, the access site bled and soaked through the bandage on her arm. She indicated she changed the bandage using the supplies she had in her room.</p> <p>On 12/13/24 at 3:30 p.m., during observation after the resident returned from dialysis. A dressing was covering the left forearm dialysis access site. The resident indicated the nurse had not checked the dressing for bleeding since returning earlier.</p> <p>On 12/16/24 at 9:23 a.m., reviewed the medical record of Resident 49. The resident was admitted to the facility on [DATE]. Diagnosis included but were not limited to end stage renal disease (a permanent condition that occurs when the kidneys are no longer able to function and require dialysis or a kidney transplant to sustain life), dependence on renal dialysis, type 2 diabetes mellitus with diabetic chronic kidney disease (a disease that occurs when your blood glucose, also called blood sugar, is too high).</p> <p>A Physician order, dated 4/13/24, indicated the resident was to have dialysis - FYI (for your information) - Dialysis Treatments 3 X (times) week at 10 a.m.</p> <p>A care plan, dated 4/14/24, indicated Resident 49 had a diagnosis of end stage renal disease and was at risk for complications with dialysis treatment. Interventions included but were not limited to, go to dialysis 3 days a week, to administer medications as ordered, to observe for pain at site, and to notify physician if pain is present. The record lacked a care plan for access site observation for bleeding, swelling or abnormalities.</p> <p>A Physician order, dated 4/15/24, indicated staff were to check access site for bruit (a whooshing or swooshing sound that can be heard near the access site with a stethoscope) and thrill (a vibration or buzzing sensation that can be felt by placing your fingers just above the incision line) daily on return shift. Staff were to document Y (yes) if monitored and N (no) if thrill or bruit were absent. Staff were to select chart code Other/See Nurses Notes and record findings if N (no) was selected and document abnormalities.</p> <p>A Physician order, dated 4/15/24, indicated staff were to assess vitals (blood pressure, pulse, respiration, temperature) on return from dialysis every Monday, Wednesday, and Friday. Task was scheduled to be completed on return from dialysis-on-dialysis days.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155542	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER Cloverleaf of Knightsville		STREET ADDRESS, CITY, STATE, ZIP CODE 9325 N Crawford St Knightsville, IN 47857	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A quarterly Minimum Data Set (MDS) assessment, dated 10/14/24, indicated the resident was cognitively intact.</p> <p>On 12/13/24 at 3:20 p.m., during interview with Licensed Practical Nurse (LPN) 8, she indicated the nurse checked the access site each shift after administration of dialysis.</p> <p>On 12/13/24 at 3:40 p.m., during an interview, the Director of Nursing indicated the nurse should assess the resident after the dialysis resident returned from dialysis to ensure the site was not bleeding. The DON acknowledged an order to check for bleeding at the access site had not been obtained from the physician prior to interview.</p> <p>A Physician order, dated 12/13/24, indicated twice a day staff were to check dialysis access site for bleeding every shift, and notify MD (medical doctor) if symptoms.</p> <p>On 12/16/2024 at 10:40 a.m., the Director of Nursing provided a document, titled, Dialysis dated 11/28/2016, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy .Based on comprehensive assessment of a patient, the facility must ensure that patient(s) who require dialysis receive such services, consistent with professional standards of proactive .Post Dialysis .5. Monitor shunt site on a routine basis. Notify physician if any unusual problems are noted with shunt site (tenderness, bleeding) . General guidelines .4. Monitor for any complaints or observations at vascular access site</p> <p>3.1-37(a)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155542	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER Cloverleaf of Knightsville		STREET ADDRESS, CITY, STATE, ZIP CODE 9325 N Crawford St Knightsville, IN 47857	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>34525</p> <p>Based on record review and interview, the facility failed to ensure behavior monitoring was completed for 1 of 5 residents reviewed for unnecessary medications (Resident 30).</p> <p>Findings include:</p> <p>Resident 30's record was reviewed on 12/16/24 at 9:36 a.m. The profile indicated the resident's diagnoses included, but were not limited to, alcoholic cirrhosis of the liver with ascities (a condition where the liver is damaged by chronic alcohol consumption and has a buildup of fluid in the abdomen), visual hallucinations (seeing things that are not there), other chorea (a movement disorder that causes involuntary, rapid, and irregular muscle contractions that affect the face, arms, legs, and trunk), anxiety disorder (a mental health condition that causes excessive and persistent feelings of fear, dread, and uneasiness that interfere with daily life), major depressive disorder (a mental health condition that can cause a persistent feeling of sadness, hopelessness, and a lack of interest in activities), and irregular muscle contractions that affect the face, arms, legs, and trunk.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 9/9/24, indicated the resident had no cognitive deficit and no documented behaviors.</p> <p>A care plan, with a revision date of 3/20/24, indicated the resident was at risk for ineffective coping related to a significant traumatic event. The resident was counseling a patient who committed murder. Interventions included, but were not limited to, administer medications as ordered and collaborate care with medical and psychiatric service providers as needed.</p> <p>A care plan, dated 2/4/20, indicated the resident was at risk for emotional and physical distress related to a history of physical, emotional, and mental abuse. The resident reported her former spouse threatened her with a gun. Interventions included, but were not limited to, administer medications as ordered and collaborate care with medical and psychiatric service providers as needed.</p> <p>A physician's order, dated 1/18/21, indicated to monitor behaviors of depression and tearfulness and document the number of episodes, interventions, and outcomes, every shift and as needed.</p> <p>A physician's order, dated 1/18/21, indicated to monitor behaviors of insomnia and document the number of episodes, interventions, and outcomes, every shift and as needed.</p> <p>A physician's order, dated 1/18/21, indicated to monitor behaviors of visual hallucinations and document the number of episodes, interventions, and outcomes, every shift and as needed.</p> <p>A Pharmacy recommendation, dated 2/28/24, indicated to evaluate the resident's medications of Cymbalta (antidepressant medication) 90 milligrams (mg) daily and Risperdal (antipsychotic medication) 0.5 mg at bedtime, for symptoms the depression, pain, and hallucinations, and consider dose reductions. The facility's behavior committee reported the resident was still symptomatic and recommended a dose reduction of the medications be contraindicated. The physician agreed with the behavior committee's recommendation and documented that no dose reduction should be completed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155542	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER Cloverleaf of Knightsville		STREET ADDRESS, CITY, STATE, ZIP CODE 9325 N Crawford St Knightsville, IN 47857	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's February 2024 Treatment Administration Record (TAR) and progress notes lacked documentation that the resident had exhibited any behavioral symptoms during the month.</p> <p>A Pharmacy recommendation, dated 5/29/24, indicated to evaluate the resident's medication of Ativan (antianxiety medication) 0.5 mg two times daily for anxiety. The physician indicated to continue the therapy as ordered and documented that the resident continued to be symptomatic.</p> <p>Review of the resident's May 2024 TAR, and progress notes lacked documentation that the resident had exhibited any behavioral symptoms during the month.</p> <p>A Pharmacy recommendation, dated 8/26/24, indicated to evaluate the resident's medication of Cymbalta 90 mg daily for depression and pain. The facility's behavior committee reported the resident was still symptomatic and recommended a dose reduction not be completed at that time. The physician agreed with the behavior committee's recommendation and drew an arrow which pointed to the statement of the behavior committee's recommendation and documented the continued same-symptomatic.</p> <p>Review of the resident's August 2024 TAR lacked documentation that the resident had exhibited any behavioral symptoms during the month. The progress notes for August 2024, indicated the resident was stable and lacked documentation of any behaviors during the month.</p> <p>During an interview, on 12/16/24 at 2:07 p.m., the Director of Nursing (DON) indicated the physician made his decision regarding dose reductions based upon the recommendation from the behavior committee. The behavior committee received their information about the resident's behaviors by talking with the nurses. The nurses did need more education on completing the TAR resident's exhibit behaviors.</p> <p>During an interview, on 12/17/24 at 9:20 a.m., the Social Services Director (SSD) indicated she felt the reason that the behaviors were not being documented in the TAR was related to how the new system allowed for documentation by the Certified Nursing Assistants (CNAs). Under the old company's system, the CNAs should directly document behaviors into their Point of Care (POC) system, and it went to the TAR. The new system no longer allowed for that to happen. The nurses were the only ones who were able to document on the TARs. The nurses were lax in documentation of behaviors.</p> <p>On 12/17/24 at 2:43 p.m., the DON provided a document, with a revision date of September 2022, titled, Behavioral Assessment, Intervention, and Monitoring, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy Interpretation and Implementation .Assessment .3. The nursing staff will identify, document, and inform .about specific details regarding changes in an individual's .behavior .4. New onset or changes in behavior will be documented .Monitoring: 1 .the IDT (interdisciplinary team) will . document .improvements or worsening in the individual's behavior</p> <p>3.1-43(a)(1)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155542	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER Cloverleaf of Knightsville		STREET ADDRESS, CITY, STATE, ZIP CODE 9325 N Crawford St Knightsville, IN 47857	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>48226</p> <p>Based on observation and record review, the facility failed to ensure a medication error rate of less than 5 percent with an error rate of 21.43 percent for 3 of 4 residents reviewed for medication administration (Residents 169, 14 and 26).</p> <p>Findings include:</p> <p>1. On 12/17/24 at 7:45 a.m., observed Registered Nurse (RN) 15, prepare and administer medications to Resident (169). Ferrous Sulfate 1 tablet and Klor-Con 1 tablet were removed from medication card and crushed. Medications were then administered to the resident in applesauce.</p> <p>On 12/17/24 at 9:30 a.m., the medical records of Resident 169 were reviewed. The resident was admitted with diagnosis including but not limited to anemia (a condition that develops when your blood produces a lower-than-normal amount of healthy red blood cells) and hypokalemia (a condition where the level of potassium in your blood is lower than normal).</p> <p>Physician orders included but not limited to administer 1 tablet ferrous sulfate EC (enteric coated) (tablets or capsules with a coating that prevents the medication from dissolving in the stomach and instead allows it to pass into the small intestine, where it can be absorbed) 325 mg (milligrams) administer by mouth once daily for anemia, and administer 1 tablet Klor-Con 20 meq (milliequivalent) administer by mouth once daily for hypokalemia.</p> <p>On 12/17/24, the Director of Nursing (DON) provided a document titled, oral dosage forms that should not be crushed. The list included medications that were enteric coated (EC) and Klor-Con a slow-release medication (medications that release a consistent amount of the drug over a longer period of time).</p> <p>2. On 12/17/24 at 8:05 a.m., observed Registered Nurse (RN) 15 prepare and administer medications to Resident (14). Ferrous sulfate 1 tablet and Myrbetriq ER 1 tablet were removed from medication card and crushed. Medications were then administered to the resident in applesauce.</p> <p>On 12/17/24 at 10:00 a.m., the medical record of Resident 14 was reviewed. The resident was admitted with diagnosis including but not limited to, anemia, benign prostatic hyperplasia (a condition in which the prostate gland is larger than normal).</p> <p>Physician orders included but were not limited to an order, dated 2/2/24, for 1 tablet ferrous sulfate EC (enteric coated) 325 mg to be administered by mouth once a day for anemia.</p> <p>A physician order, dated 2/2/24, for 1 tablet Myrbetriq ER (extended release) to be administered by mouth once a day for overactive bladder.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155542	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER Cloverleaf of Knightsville		STREET ADDRESS, CITY, STATE, ZIP CODE 9325 N Crawford St Knightsville, IN 47857	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/17/24, the Director of Nursing (DON) provided a document titled, oral dosage forms that should not be crushed. The list included medications that were enteric coated (EC) and Klor-Con a slow-release medication (medications that release a consistent amount of the drug over a longer period of time). The medications Myrbetriq (mirabegron) and Ferrous sulfate were listed as slow-release medication on the do not crush document.</p> <p>3. On 12/17/24 at 9:00 a.m., observed Registered Nurse (RN) 17 prepare and administer Basaglar insulin and Admelog SoloStar insulin to Resident (26). RN 7 adjusted the insulin pens to the prescribed dose to be administered to the resident. The RN did not prime the insulin administration pen according to manufacture guidelines. Priming the pen ensures all of the prescribed insulin was administered to the resident by removing the air space within the needle.</p> <p>The RN went into the resident's room, left the door open and did not pull the curtain to provide privacy to the resident. The RN advised the resident that she was going to administer the insulin in his abdomen. The RN administered the insulin and counted to ten during administration of insulin, and immediately removed the insulin needle.</p> <p>On 12/17/24 at 10:30 a.m., the medical record of Resident 26 was reviewed. The resident was admitted with diagnosis including but not limited to Type 2 diabetes mellitus (a disease that occurs when your blood glucose, also called blood sugar, is too high).</p> <p>A Physician orders included but were not limited to. An order, dated 7/7/24, for Basaglar insulin 100 unit/ml (milliliter) 40 units subcutaneously (under the skin) two times a day for type 2 diabetes.</p> <p>A Physician order, dated 11/19/24, Admelog SoloStar insulin 100 unit/ml. Administer as per sliding scale (a type of insulin prescription that adjusts the amount of insulin a person takes based on their blood sugar level) before meals.</p> <p>On 12/17/24 at 9:05 a.m., during interview, RN 17 indicated she did not know if the insulin pen should be primed before administration, and indicated she counted to ten while administering the insulin. She acknowledged she should have closed the door when she administered insulin to the resident.</p> <p>On 12/17/2024 at 1:57 p.m., the Director of Nursing (DON) provided a document, titled, SOP-Insulin Preparation and Administration, dated 5/20/20, and indicated it was the policy currently being used by the facility. The policy indicated, .2. Procedure .h. Procedure for insulin pen .v. Attach need to the pen .vii. Remove air from insulin pen .1. Turn the dial to 2 units .3. Gently tap pen to remove air bubbles .viii. Press the inject button .Select the correct dose of insulin on the pen by turning the dial to the number of units you need to inject .3. Insulin Administration Procedure .b. provide privacy .i. Close doors, curtains and or room curtains as needed .j. insert needle .k. push plunger with thumb at a moderate steady pace until insulin is completely administered, approximately 5-10 seconds</p> <p>3.1-48(c)(1)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155542	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER Cloverleaf of Knightsville		STREET ADDRESS, CITY, STATE, ZIP CODE 9325 N Crawford St Knightsville, IN 47857	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>48226</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure medication were labeled properly for 3 of 4 medication carts reviewed for medication storage (Residents 58, 26, and 2).</p> <p>Findings include:</p> <p>On 12/17/25 at 8:00 a.m., medication storage cart A was observed. Tresiba Insulin pen prescribed for Resident 2. Pharmacy dispensed date was 11/14/24. Date opened was not indicated on the insulin pen.</p> <p>On 12/17/24 at 8:20 a.m., medication storage cart 1 was observed. Lantus Insulin pen prescribed for Resident 58. Pharmacy dispensed date was 11/19/24. Date opened was not indicated on the insulin pen.</p> <p>On 12/17/24 at 9:00 a.m., medication storage cart B was observed. Basaglar Insulin pen prescribed for Resident 26. Pharmacy dispensed date was 11/28/24. Date opened was not indicated on the insulin pen.</p> <p>On 12/17/24 at 8:05 a.m., during interview Registered Nurse (RN) 15 indicated insulin pens should be dated when opened and an expiration date added to label.</p> <p>On 12/17/24 at 9:05 a.m., during interview Qualified Medication Aide (QMA) 18 indicated insulin pens should be dated when opened and an expiration date added.</p> <p>On 12/17/24 at 9:08 a.m., during interview RN 17 indicated insulin pens must be dated when opened, if no date was on the pen or if in doubt the pen was thrown out.</p> <p>On 12/17/24 at 9:30 a.m., the medical record of Resident 58 was reviewed. The resident was admitted to the facility with diagnosis including but not limited to, Type 2 diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), and acute kidney failure (a condition where the kidneys suddenly stop working properly).</p> <p>A Physician Order, dated 12/12/24, for Lantus SoloStar insulin 100 units/ml (milliliter), inject 10 units subcutaneous (under the skin) daily for diabetes.</p> <p>On 12/17/24 at 9:40 a.m., the medical record of Resident 26 was reviewed. The resident was admitted with diagnosis including but not limited to, Type 2 diabetes, chronic obstructive pulmonary disease (COPD) (a group of diseases that cause airflow blockage and breathing-related problems).</p> <p>A Physician order, dated 7/7/24, for Basaglar insulin 100 units/ml inject 40 units subcutaneous (under the skin) daily for diabetes.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155542	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER Cloverleaf of Knightsville		STREET ADDRESS, CITY, STATE, ZIP CODE 9325 N Crawford St Knightsville, IN 47857	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/17/24 at 10:00 a.m., the medical record of Resident 2 was reviewed. The resident was admitted with diagnosis including but not limited to, type 2 diabetes, and chronic kidney disease (the kidneys are damaged and can't filter blood the way they should).</p> <p>A Physician order, dated 10/15/24, for Tresiba flex touch insulin solution 100units/ml, inject 15 units subcutaneous daily for type 2 diabetes.</p> <p>On 12/17/2024 at 1:57 p.m., the Director of Nursing (DON) provided a document, titled, Specific Procedures for all Medications, dated 5/20/20, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure .5. Check expiration date on package/container. When opening a multidose container, place the date on the container, place the date on the container</p> <p>3.1-25(j)</p> <p>3.1-25(m)</p> <p>3.1-25(n)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155542	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER Cloverleaf of Knightsville		STREET ADDRESS, CITY, STATE, ZIP CODE 9325 N Crawford St Knightsville, IN 47857	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48226</p> <p>Based on interview, observation and record review, the facility failed to honor food preferences of 1 of 1 resident reviewed for dietary preferences (Resident 49)</p> <p>Findings include:</p> <p>On 12/12/24 at 11:25 a.m., during observation and interview, Resident 49 indicated she had asked several times not to be served vegetables and the facility continued to put them on her plate.</p> <p>On 12/12/24 at 12:27 p.m., observation of the dietary tray slip of Resident 49 indicated the dietary slip food dislikes did not indicate the resident did not want vegetables.</p> <p>On 12/16/24 at 9:00 a.m., the medical record of Resident 49 was reviewed. The resident was admitted to the facility on [DATE]. Diagnosis included but were not limited to end stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life, dependence on renal dialysis (a treatment that filters waste and excess fluid from your blood when your kidneys can no longer perform this function), and type 2 diabetes mellitus (a disease that occurs when your blood glucose, also called blood sugar, is too high) with diabetic chronic kidney disease (the kidneys are damaged and can't filter blood the way they should).</p> <p>A Physician order, dated 4/15/24, ordered a CCHO (controlled carbohydrate) diet, regular texture, thin (liquids) consistency. Only one serving of dairy daily, no oatmeal or sausage no more OJ (orange juice) no more juices until CA (calcium) levels lower, no pudding, cottage cheese, no milk products, limit amount of breads, pizza, cereal, crackers.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 10/14/24, indicated the resident was cognitively intact.</p> <p>A care plan, dated 4/14/24, indicated the resident was at nutritional risk. Interventions included but were not limited to RD (Registered Dietitian) to evaluate and make diet change recommendations as needed, and to provide Diet: CCHO regular texture, thin consistency, 1800 ml (milliliters) fluid restriction.</p> <p>Review of activity preference form, dated 4/16/24, which was completed on admission the record did not indicate any dietary preferences.</p> <p>On 12/12/24 at 12:25 p.m., during an interview, Employee 7 indicated the residents choose from a menu each day and decide what they want to eat. If they do not want what was served they could get the substitute. She indicated the activities department staff asked the residents their preferences and recorded it on the diet menu selection forms.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155542	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER Cloverleaf of Knightsville		STREET ADDRESS, CITY, STATE, ZIP CODE 9325 N Crawford St Knightsville, IN 47857	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/16/24 at 11:01 a.m., during an interview, Employee 6 indicated she asked the residents daily if they wanted what was on the menu. She recorded choices and turned it into dietary department. She indicated the preferences were then recorded on the diet slip and indicated Resident 49 had told her previously she did not like vegetables.</p> <p>On 12/16/24 at 11:08 a.m., during an interview the Administrator indicated she updated the dietary tray slip all the time. She provided a copy of the current dietary tray slip for Resident 49 and indicated the resident did not like cooked vegetables and it was on the updated dietary slip.</p> <p>On 12/16/2024 at 2:45 p.m., the Administrator provided a document, titled, Resident Food Preferences , dated 7/2023, and indicated it was the policy currently being used by the facility. The policy indicated, . Individual food preferences will be assessed upon admission and updated as needed. Reasonable efforts will be made to accommodate resident choices and preferences .2. When possible, staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes</p> <p>3.1-20(c)(7)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155542	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER Cloverleaf of Knightsville		STREET ADDRESS, CITY, STATE, ZIP CODE 9325 N Crawford St Knightsville, IN 47857	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35317</p> <p>Based on observation, interview, and record review, the facility failed to ensure undated and expired foods were disposed of for 1 of 2 kitchen observations.</p> <p>Findings include:</p> <p>During a food storage observation with [NAME] 3 on [DATE] at 9:50 a.m., the walk in refrigerator contained a clear plastic container with a lid that had corn, the corn was dated [DATE]. There was a clear plastic bag of lettuce with a delivery dated [DATE], the lettuce was brown and wilted inside the bag. Three cucumbers were found on a shelf in an open and undated plastic bag.</p> <p>During an interview, on [DATE] at 9:52 a.m., [NAME] 3 indicated food was good for 3 days once it was opened and placed in a new container. She indicated the corn should have been disposed of by now and the lettuce was no longer good because it was delivered in October and was brown and wilted. She was unsure why they hadn't been disposed of them by now because she was not the person responsible for that. [NAME] 3 indicated food should be labeled once it was delivered to the facility and she had no idea when the cucumbers were delivered and how long they were in the walk-in refrigerator. The cucumbers would have to be disposed of since they were not labeled properly.</p> <p>On [DATE] at 10:30 a.m., the Administrator provided an undated document, titled, Keeping Food Safe for the Residents in Cloverleaf Facility, and indicated it was the policy currently being used by the facility. The policy indicated, .8. When to Discard Food .c. Food is over 72 hours old. d. If there is no identification or date on the item</p> <p>On [DATE] at 12:57 p.m., the Administrator provided a document with a revised date of [DATE], titled, Food Receiving and Storage, and indicated it was the policy currently being used by the facility. The policy indicated, .Foods shall be received and stored in a manner that complies with safe food handling practices . 7. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date)</p> <p>3XXX,d+[DATE](i)(3)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155542	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER Cloverleaf of Knightsville		STREET ADDRESS, CITY, STATE, ZIP CODE 9325 N Crawford St Knightsville, IN 47857	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>48226</p> <p>Based on record review and interview, the facility failed to follow the antibiotic stewardship protocol program for 1 of 5 residents reviewed for antibiotics (Resident 46).</p> <p>Findings include:</p> <p>On 12/17/24 11:14 a.m., the medical record of Resident 46 was reviewed. The resident was admitted to the facility with diagnosis of, but not limited to, Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), chronic obstructive pulmonary disease (COPD) (a group of diseases that cause airflow blockage and breathing-related problems), urinary retention (a medical condition that occurs when a person is unable to empty their bladder or has difficulty starting or maintaining a steady urine flow), and history of recurrent urinary tract infections (bacteria in the urine, resulting in an infection).</p> <p>A Physician order, dated 8/31/24, indicated to administer one capsule of Ampicillin 500 mg (milligram) via (by way of) G-tube (a tube that is surgically inserted through the abdomen and into the stomach to provide nutrition, fluids, and medicine) daily for prophylactic (something that prevents or protects).</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 11/11/24, indicated the resident had a cognition deficit, required max assistance of two persons, received nutrition and medications through gastric tube and was currently on an antibiotic.</p> <p>A care plan, dated 11/11/24, indicated the resident was on antibiotic therapy related to recurrent urinary tract infections. Interventions included but not limited to, collect labs as ordered and report results to physician, administer medications as ordered, and notify physician of any change or worsening of condition.</p> <p>The medical record indicated the resident had been on an antibiotic since previous admission. Documentation lacked evidence of physician assessment to determine the need for prophylactic long-term use of an antibiotic. Documentation lacked evidence of physician education or education being provided to the responsible party regarding long term use of antibiotics.</p> <p>On 12/17/24 at 2:00 p.m., during an interview, the Director of Nurses (DON) indicated the resident was on antibiotic therapy for history of chronic urinary tract infections. She indicated the resident was admitted with the antibiotic and diagnosis of VRE (Vancomycin-Resistant Enterococci, is a type of bacteria that has become resistant to many antibiotics, including vancomycin) and indicated the antibiotic had been administered for some time at the previous facility the resident resided in. She indicated the resident had multiple urinalysis (analysis of urine by microscopical means to test for the presence of disease) and culture (a lab test that checks for bacteria or other microorganisms in urine to help diagnose a urinary tract infection (UTI) of the urine) while at the other facility. A urinalysis and culture were completed at the facility upon admission and no additional testing had been repeated.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155542	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER Cloverleaf of Knightsville		STREET ADDRESS, CITY, STATE, ZIP CODE 9325 N Crawford St Knightsville, IN 47857	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/18/24 at 1:00 p.m., during review of the antibiotic stewardship program with the DON and Infection Prevention Nurse, both indicated the facility utilized the McGeer's criteria surveillance tools for infections in the long-term care facility.</p> <p>On 12/18/24 at 2:30 p.m., during interview with the Medical Director and the DON. The Medical Director indicated the resident was on long term antibiotics because the family wanted her to be on an antibiotic due to previous history of urinary tract infections. The Medical Director acknowledged the resident was probably resistant to penicillin, (resistance occurs when bacteria develop the ability to withstand the effects of antibiotics), since she had VRE when she was admitted . He indicated at the time of admission the bacteria causing the infection was sensitive to the antibiotic. (Sensitivity occurs when a bacterial pathogen is inhibited or not inhibited by exposure to certain antibiotics). The Medical Director indicated he would be discontinuing the medication and trying alternate non-antibiotic measures to prevent re-occurrence of infection.</p> <p>On 12/11/2024 at 11:00 a.m., the Administrator provided a document titled, Antibiotic Stewardship, dated July 20, 2018, and indicated it was the policy currently being used by the facility. The policy indicated, .1. The purpose of our Antibiotic Stewardship Program is to monitor the use of antibiotics in our residents .4. If an antibiotic is indicated, prescribers will provide complete antibiotic orders including the following elements .d. Duration of treatment; 1. Start and Stop Date, or 2. Number of days of therapy</p> <p>The Centers for Disease Control and Prevention (CDC) webpage, The Core Elements of Antibiotic Stewardship, accessed online at: https://www.cdc.gov/antibiotic-use/hcp/core-elements, indicated, . Improving antibiotic prescribing and use is critical to effectively treat infections, protect patients from harms caused by unnecessary antibiotic use, and combat antibiotic resistance</p>		