

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/05/2024
NAME OF PROVIDER OR SUPPLIER Clark Rehabilitation and Skilled Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 517 N Little League Blvd Clarksville, IN 47129	

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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>35732</p> <p>Based on observation, record review, and interview, the facility failed to ensure showers were provided consistently for 2 of 4 residents reviewed for Activities of Daily Living care. (Residents 19 and 67)</p> <p>1. The record for Resident 19 was reviewed on 4/1/24 at 11:03 a.m. The resident's diagnoses included, but were not limited to, sepsis, muscle weakness, vascular dementia, personal history of traumatic brain injury, anxiety, flaccid hemiplegia affecting the left nondominant side and bipolar disorder.</p> <p>The care plan, dated 8/5/18 and revised on 2/20/24, indicated the Resident required assistance with ADLs (activities of daily living) included bed mobility, transfers, eating and toileting. The interventions included, but were not limited to, assist with oral care at least two times daily, and assist with bathing as needed per resident preference. Staff were to offer the resident's showers two times per week and provide a partial bath in between.</p> <p>The Quarterly MDS (Minimum Data Set) assessment, dated 2/15/24, indicated the resident was severely cognitively impaired. He was dependent on staff for his oral hygiene and bathing.</p> <p>The residents shower schedule indicated the following:</p> <ul style="list-style-type: none"> - January 4 through January 31, 2024, the resident did not have a shower. - February 1 through February 29, 2024, the resident had a shower on 2/9/24 and 2/23/24. There were no other documented showers for the month of February. - March 1 through March 30, 2024, the resident had a shower on 3/22/24. There were no other documented showers for the month of March. <p>During an interview on 4/5/24 9:25 a.m., LPN (Licensed Practical Nurse) 5 indicated the resident should have received a shower two times a week. The only reason a resident wouldn't receive a shower was if they were out of the facility or the resident refused.</p> <p>2. During an observation on 4/1/24 at 11:36 a.m., Resident 67 was observed with a soiled brief, dried, peeling skin on his mouth and lips, and his teeth had a thick crusty yellowish buildup. The resident only had a tee shirt and a soiled brief. He was not covered and there was a strong urine odor.</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
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The resident's record was reviewed on 4/1/24 at 11:06 a.m. The diagnoses included, but were not limited to, nontraumatic intracerebral hemorrhage, aphasia, dysarthria and dysphagia following a nontraumatic intracerebral hemorrhage, abnormalities of gait and mobility, and dorsalis.</p> <p>The Quarterly MDS assessment, dated 2/22/24, indicated the resident was severely cognitively impaired. He was dependent on staff for his oral hygiene and bathing.</p> <p>The care plan, dated 2/20/24, indicated the resident required assistance with ADLs (included bed mobility, transfers, eating and toileting. The interventions included, but were not limited to, assist with oral care at least two times daily, and assist with bathing as needed per resident preference. Staff were to offer the resident's showers two times per week, and a partial bath in between.</p> <p>The residents shower documentation indicated for the months of February and March the resident did not receive a shower.</p> <p>During an interview on 4/4/24 at 1:49 p.m., CNA (Certified Nurse Aide) 8 indicated the resident was supposed to take his showers on the evening shift. She indicated the resident was able to get up in a chair. There would be no reason he could not take a shower.</p> <p>During an interview on 4/4/24 at 2:00 p.m., CNA 9 indicated she was able to complete her resident showers. Sometimes they would get backed up, but they usually got done. Sometimes the residents would refuse a shower and they didn't always get a chance to get back to to them. They were able to stay on schedule most of the time. If they had a refusal or hospice came in to give a hospice resident their bath they would go back and ask the resident that refused if they were ready to take their shower. The residents should receive two showers a week.</p> <p>The facility did not present a policy for Activities of Daily Living.</p> <p>3.1-38(a)(3)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>34309</p> <p>Based on observation, interview, and record review the facility failed to ensure a splint device was provided to prevent a decrease in range of motion for 1 of 3 residents reviewed for range of motion. (Resident 40)</p> <p>Findings include:</p> <p>The record for Resident 40 was reviewed on 4/3/24 at 2:07 p.m. The resident's diagnoses included, but were not limited to, hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting the left non-dominant side, spastic hemiplegia affecting the left nondominant side, attention and concentration deficit following cerebral infarction, spastic hemiplegia affecting left dominant side, muscle weakness, and need for assistance with personal care.</p> <p>The care plan, dated 9/13/19, indicated the resident required assistance with ADLs (Activities of Daily Living) including bed mobility, and transfers related to a decrease in strength and an increase in weakness, and a CVA (cardiovascular accident) with left sided hemiplegia. The interventions, dated 11/12/19, included, but were not limited to, apply the LUE (left upper extremity) hand splint up to two hours per day and a LUE elbow splint up to six hours per day as tolerated.</p> <p>The physician's order, dated 6/27/22, indicated the resident was to wear a resting hand splint to her left hand for two to four hours per day as tolerated and to perform PROM (passive range of motion) to the left hand prior to the splint placement once a day from 7:00 a.m. to 11:00 a.m.</p> <p>The Quarterly MDS (Minimum Data Set) assessment, dated 7/25/23, indicated the resident was cognitively intact. She was dependent on staff for upper and lower body dressing, putting on footwear, and showering.</p> <p>The Annual MDS assessment, dated 12/15/23, indicated the resident was cognitively intact.</p> <p>During an observation on 4/1/24 at 9:50 a.m., the resident was sitting in her wheelchair. There was no splint on her left hand. She indicated it was in her drawer and she pulled it out of the drawer to show where it was.</p> <p>During an observation on 4/2/24 at 10:24 a.m., the resident's brace was not on her left arm and hand. She indicated if staff would assist her to put the brace on her, she would wear it. The resident's left hand was contracted.</p> <p>During an observation and interview on 4/4/24 at 10:25 a.m., the resident indicated it had been a while since the brace had been applied to her arm and hand, and it had been at least six months. She thought she was supposed to wear it for about six hours. She got the brace about a year ago. Therapy didn't work with her much now. The brace held her arm and hand in place when she wore it. The resident tried to pull the Velcro straps open, but had to catch it from dropping twice. She was unable to apply the brace on her own.</p> <p>(continued on next page)</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/4/24 at 12:59 p.m., Occupational Therapist 4 indicated the resident had contractures to the left hand from a stroke prior to admission. She was not currently on case load for therapy. The resident was discharged from occupational therapy, on 1/15/24, because she met her goals and achieved her highest strength level. Splinting was included in the therapy. She had a resting splint for her hand. The splint was still ongoing and nursing staff now applied the splint. It was part of the splint placement to do ROM (range of motion) exercises. She was screened quarterly to make sure that was being done. She had not come up for the quarterly assessment yet.</p> <p>During an interview on 4/4/24 at 1:21 p.m., CNA (Certified Nurse Aide) 3 indicated the resident used to have a leg brace and a wrist brace. She had not seen a brace on the resident's arm. The resident was very compliant and had come a long way.</p> <p>During an interview on 4/4/24 at 1:23 p.m., LPN (Licensed Practical Nurse) 5 indicated the resident was total care. She transferred with a sit to stand. Restorative nursing was a different area, she didn't know about that. She had a brace and therapy was working on getting her another one. She wasn't sure about the hand brace because it was applied by restorative.</p> <p>During an interview on 4/4/24 at 2:01 p.m., the Corporate MDS Coordinator indicated she filled in when the MDS restorative was out. She came in only when asked to see residents. The resident had a splinting program six days weekly for her left leg and a transfer program using parallel bars six days a week. Restorative performed a wheelchair to parallel bar transfer for fifteen minutes. The splint device area was washed, and a skin assessment was conducted for the left knee. The physician's order for the arm splint was not done by restorative. She had an order for the hand splint 2 to 4 hours per day and that would be performed by the nurse.</p> <p>During an interview on 4/5/24 at 8:47 a.m., LPN 5 indicated she put the hand brace on the resident this morning at 7:30 a.m., after being asked questions about the splint. The order indicated the brace was to be provided for the resident 2 to 4 hours. She would also perform ROM if needed.</p> <p>During an interview on 4/5/24 at 9:46 a.m., LPN 6 indicated the facility had no policy for applying splints or braces.</p> <p>3.1-42(a)(2)</p>		