

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155673	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MARKLE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 170 N TRACY ST MARKLE, IN 46770
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	<p>This visit was for the Investigation of Complaint IN00179788.</p> <p>Complaint IN00179788- Substantiated. Deficiency related to the allegations is cited at F 312.</p> <p>Survey dates: August 17 and 18, 2015</p> <p>Facility number: 000544 Provider number: 155673 AIM number: 100267340</p> <p>Census bed type: SNF/NF: 69 Total: 69</p> <p>Census payor type: Medicare: 2 Medicaid: 54 Other: 13 Total: 69</p> <p>Sample: 3</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>F0000Credible Allegation of Compliance &amp; Request for Paper Compliance. The creation &amp; submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance &amp; REQUESTS A DESK REVIEW FOR CERTIFICATION OF COMPLIANCE.</p>	
------------------------	---	--------	--	--

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155673		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/18/2015	
NAME OF PROVIDER OR SUPPLIER  MARKLE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 170 N TRACY ST MARKLE, IN 46770			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0312 SS=D Bldg. 00	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, interview, and record review, the facility failed to provide frequent trimming of toenails to keep toenails short for 2 of 3 residents reviewed for toenail hygiene in a sample of 3. (Resident #E and Resident #G)</p> <p>Findings include:</p> <p>1. An observation on 8-18-2015 at 10:13 AM indicated Resident #E had toenails approximately 1/4 inch longer than the end of his toes on the third and fourth toe of both the left and the right foot.</p> <p>Resident #E's record was reviewed on 8-18-2015 at 9:37 AM. Resident #E's diagnose's included, but were not limited to, depression, dementia, and high blood pressure.</p> <p>Resident #E's Quarterly MDS (Minimum Data Set) dated 7-13-2015 indicated in section G Resident #E required and received 1 person extensive assist with personal hygiene.</p>	F 0312	<p>F0312 I. Corrective Action Taken: It is the practice of this facility to ensure that any resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Residents "E" &amp; "G" had their toenails trimmed by facility podiatrist on 8/26/15. II. Identification of Other Residents: All residents have the potential to be affected by this deficient practice. A facility wide toenail sweep was performed by licensed personnel on 8/25/15 to identify any other residents needing toenails trimmed. III. Measures Put in Place: Nursing staff were inserviced on the care of toenails. The inservice was completed by the Clinical Education Coordinator on 8/31/15. The podiatrist treated residents at the facility on 8/26/15. The podiatrist revised his schedule from a three month rotation to a two month rotation, enabling residents to be seen more frequently. The new rotation is effective with the podiatrists September visit. The podiatrist is scheduled to return to</p>	09/10/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155673		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/18/2015	
NAME OF PROVIDER OR SUPPLIER  MARKLE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 170 N TRACY ST MARKLE, IN 46770			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>In an interview on 8-18-2015 at 10:25 AM, the Memory Care Facilitator indicated Resident #E had seen the podiatrist on 6-17-2015, but she was unsure of the procedures performed for Resident #E as she had only begun employment with the facility on 7-13-15.</p> <p>A review of Resident #E's Podiatry Progress Note dated 6-17-15 indicated Resident #E's toenails were "debrided using nail nippers and a rasp".</p> <p>In an interview on 8-18-2015 at 1:36 PM, LPN #1 indicated staff should trim toenails that could be trimmed, and if nails are long, and staff are not able to trim them, the staff should alert the nurse, and the Memory Care Facilitator to get toenails trimmed.</p> <p>2. In an observation on 8-18-2015 at 10:13 AM, Resident #G was observed to have toenails approximately 1/8 inch longer than the end of his toes on the fourth toe of both the left and the right foot and the toenails had jagged edges.</p> <p>Resident #G's record was reviewed on 8-18-2015 at 11:37 AM. Resident #G's diagnose's included, but were not limited to, depression, dementia, and high blood pressure.</p>		<p>the facility on 9/10/15. IV. Monitoring of Corrective Action Taken:DNS/designee will monitor compliance by completion of a QCI tool. The tool will be completed monthly x six months. Results will be reviewed by the CQI committee overseen by the Administrator. If threshold of 95% has not been achieved, an action plan will be developed to ensure compliance.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155673	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  08/18/2015
NAME OF PROVIDER OR SUPPLIER  MARKLE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 170 N TRACY ST MARKLE, IN 46770		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>Resident #G's Quarterly MDS (Minimum Data Set) dated 6-3-2015 indicated in section G the resident required and received 1 person extensive assist with personal hygiene.</p> <p>A review of Resident #G's Podiatry Progress Note dated 6-17-2015 indicated Resident #G's toenails were "debrided using nail nippers and a rasp".</p> <p>This Federal tag is related to complaint IN00179788.</p> <p>3.1-38(a)(3)(E)</p>				