

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155799	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/20/2014
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NAME OF PROVIDER OR SUPPLIER MARION REHABILITATION AND ASSISTED LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953
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F000000	<p>This visit was for the investigation of Complaints IN00150283 and IN00150564.</p> <p>Complaint # IN00150283 - Substantiated. Federal/state deficiencies related to the allegations are cited at F250, F312, F314 and F516.</p> <p>Complaint #IN00150564- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Unrelated deficiencies are cited at F225, F226 and F356.</p> <p>Survey dates: June 19 & 20, 2014</p> <p>Facility number: 012809 Provider number: 155799 AIM number: 2011365580</p> <p>Survey team: Shelley Reed, RN TC Jason Mench RN Angela Selleck RN</p> <p>Census bed type: SNF: 41 SNF/NF: 11 Residential: 26 Total: 78</p>	F000000		

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.

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F000225 SS=D	<p>Census payor type: Medicare: 23 Medicaid: 11 Other: 44 Total: 78</p> <p>Sample: 8</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by Debora Barth, RN.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged</p>						

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	<p>violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to report a sexually inappropriate statement made by a resident (Resident E) towards another resident (Resident D) to the appropriate agency for 1 of 1 residents reviewed for sexual abuse. (Residents D and E) Findings include:</p> <p>During a review of "Concern/Grievance Log", provided by the interim Social Service Director on 6/19/14 at 10:45 a.m., a concern of "sexually inapp."</p>	F000225	<p>F225 483.13(c)(1)(ii)-(iii),(c)(2)-(4) The facility will report sexually inappropriate statements made by any resident towards another resident to the appropriate agency.</p> <p>Residents D and E were interviewed by Social Services and indicated that they had no further concerns.</p> <p>The facility will review grievance logs for the past 60 days to</p>	07/16/2014

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	<p>(sexually inappropriate behavior) was noted on 6/2/14.</p> <p>During an interview with the Director of Nursing (DoN) on 6/19/14 at 11:45 a.m., she indicated the sexually inappropriate comment occurred on 6/2/14, between Resident E and Resident D. She indicated the incident was not reported to the state agency (ISDH) because "the definition of sexual inappropriate is not defined as abuse".</p> <p>Resident D's clinical record was reviewed on 6/19/14 at 11:20 a.m. Diagnoses included, but were not limited to, debility, congestive heart failure and anxiety. A review of Resident D's Minimum Data Set Assessment (MDS) indicated the Resident was cognitively intact.</p> <p>During an interview with Resident D on 6/19/14 at 11:10 a.m., Resident D indicated Resident E was verbally sexually inappropriate with her. She indicated she did not report this, but she was very uncomfortable with Resident E's comments and "he is just a dirty old man". She indicated she was afraid for residents who could not defend themselves. Resident D indicated comments stated by Resident E towards her were "want to get in bed with me",</p>		<p>ensure that no other instances of sexually inappropriate comments were identified.</p> <p>Executive Director and Director of Nursing will review reporting requirements and follow-up with reviewing all grievances submitted during morning communication meetings. Any grievances on the Reporting Requirements listing will be reported in a timely manner.</p> <p>Tracking and trending of grievance reports will be done by Social Services Dept. and forwarded to QA&A committee for review monthly times 3 months then quarterly thereafter. Committee will advise any follow-up action which needs to be taken.</p>	

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	<p>"take off your clothes" and "want to play with each other t---". She indicated these comments always happened near the nurses station where the residents gathered. She indicated Resident E always wanted to sit beside her.</p> <p>Resident E's clinical record was reviewed on 6/19/14 at 1:00 p.m. Diagnoses included, but were not limited to, diabetes, chronic obstructive pulmonary disease, depression and heart failure. A review of Resident E's MDS indicated the resident had some mild cognitive impairment.</p> <p>During an interview with the Corporate Nurse on 6/19/14 at 1:30 p.m., she indicated Resident E's comment to Resident D was "Show me your t---". She indicated this was not reported because it did not meet the guidelines for reporting to the State.</p> <p>No further information on the investigation of this incident was provided.</p> <p>A policy, "ABUSE PREVENTION, INTERVENTION, INVESTIGATION & CRIME REPORTING POLICY", dated September of 2011, provided by the Director of nursing on 6/19/14 at 4:28 p.m., indicated:</p>						

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	<p>"...Reporting</p> <p>Regulations require employees that provide services to elderly persons or dependant adults (mandated reporters) to report instances of suspected or allegations of abuse, neglect, or misappropriation of resident property to the local ombudsman or local law enforcement agency and to State Licensing and Certification immediately or as soon as practically possible within 24 hours of detection. The duty to report belongs to the individual mandated reporter, and the facility will not interfere with this duty.</p> <p>Additionally, the facility requires that employees immediately report the facts of known or suspected instances of abuse and all allegations of abuse and suspicions of crime immediately to the facility Administrator (either directly or anonymously) so that facility's responsibility to protect residents and promptly investigate occurrences may be met. Failure to report in the required time frames may result in disciplinary action, including termination.</p> <p>The facility Administrator, or designee, will immediately, or as soon as practically possible within 24 hours of</p>						

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F000226 SS=D	<p>receiving an allegation or forming a suspicion, report the instance of abuse, neglect, or misappropriation of resident property to the local ombudsman or local law enforcement agency and to the Department of Health Services (or appropriate state agency" as required by law.</p> <p>The facility administrator, or designee, shall report the findings of the internal investigation to officials in accordance with state law, including to the state survey and certification agency, within five working days of the incident..."</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to implement their policy related to an incident of a sexually inappropriate statement by a resident (Resident E) towards another resident</p>	F000226	F226 - 483.13(c) The facility will implement the existing policy related to dealing with sexually inappropriate statements made to residents.	07/16/2014	

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	<p>(Resident D) for 1 of 1 residents who was reviewed for sexual abuse. (Residents D and E)</p> <p>Findings include:</p> <p>During a review of "Concern/Grievance Log", provided by the interim Social Service Director on 6/19/14 at 10:45 a.m., a concern of "sexually inapp." (sexually inappropriate behavior) was noted on 6/2/14.</p> <p>During an interview with the Director of Nursing (DoN) on 6/19/14 at 11:45 a.m., she indicated the sexually inappropriate comment on 6/2/14, occurred between Resident E and Resident D and the incident was not reported to the Indiana State Department of Health (ISDH) because "the definition of sexual inappropriate is not defined as abuse".</p> <p>Resident D's clinical record was reviewed on 6/19/14 at 11:20 a.m. Diagnoses included, but not limited to, debility, congestive heart failure and anxiety. A review of Resident D's Minimum Data Set Assessment (MDS) indicated the resident was cognitively intact.</p> <p>During an interview with Resident D on 6/19/14 at 11:10 a.m., Resident D indicated Resident E was verbally</p>		<p>Residents D and E were interviewed by Social Services and indicated that they had no further concerns.</p> <p>The facility will review grievance logs for the past 60 days to ensure that no other instances of sexually inappropriate comments were identified. If any are found, they will be investigated and reported as per company policy.</p> <p>Executive Director and Director of Nursing will review reporting requirements. Follow-up will be implemented by reviewing all grievances during morning communication meetings and follow reporting requirements as needed.</p> <p>Tracking and trending of grievance reports, including sexually inappropriate statements will be done by Social Services Dept. and forwarded to QA&A committee for review monthly times 3 months then quarterly thereafter.</p>				

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	<p>sexually inappropriate with her. She indicated she did not report this, but she was very uncomfortable with Resident E's comments and "he is just a dirty old man". She indicated she was concerned about residents who could not defend themselves. Resident D indicated comments stated by Resident E towards her were "want to get in bed with me", "take off your clothes" and "want to play with each other t---". She indicated these comments always happened near the nurses station where the residents gathered. She indicated Resident E always wants to sit beside her.</p> <p>Resident E's clinical record was reviewed on 6/19/14 at 1:00 p.m. Diagnoses included, but not limited to, diabetes, chronic obstructive pulmonary disease, depression and heart failure. A review of Resident E's MDS indicated the resident had some mild cognitive impairment.</p> <p>During an interview with Corporate Nurse on 6/19/14 at 1:30 p.m., she indicated Resident E's comment to Resident D was "Show me your t---". She indicated this was not reported because it did not meet the guidelines for reporting to the State.</p> <p>No further information on the investigation of this incident was</p>			

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	<p>provided.</p> <p>A policy, "ABUSE PREVENTION, INTERVENTION, INVESTIGATION & CRIME REPORTING POLICY", dated September of 2011, provided by the Director of nursing on 6/19/14 at 4:28 p.m., indicated:</p> <p>"...Reporting</p> <p>Regulations require employees that provide services to elderly persons or dependant adults (mandated reporters) to report instances of suspected or allegations of abuse, neglect, or misappropriation of resident property to the local ombudsman or local law enforcement agency and to State Licensing and Certification immediately or as soon as practically possible within 24 hours of detection. The duty to report belongs to the individual mandated reporter, and the facility will not interfere with this duty.</p> <p>Additionally, the facility requires that employees immediately report the facts of known or suspected instances of abuse and all allegations of abuse and suspicions of crime immediately to the facility Administrator (either directly or anonymously) so that facility's responsibility to protect residents and</p>						

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F000250 SS=D	<p>promptly investigate occurrences may be met. Failure to report in the required time frames may result in disciplinary action, including termination.</p> <p>The facility Administrator, or designee, will immediately, or as soon as practically possible within 24 hours of receiving an allegation or forming a suspicion, report the instance of abuse, neglect, or misappropriation of resident property to the local ombudsman or local law enforcement agency and to the Department of Health Services (or appropriate state agency" as required by law.</p> <p>The facility administrator, or designee, shall report the findings of the internal investigation to officials in accordance with state law, including to the state survey and certification agency, within five working days of the incident..."</p> <p>3.1-28(a)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and</p>						

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	<p>psychosocial well-being of each resident. Based on interview and record review, the facility failed to track a Behavior Management Program to monitor the inappropriate behaviors for 1 of 1 residents reviewed for behavior management. (Resident E)</p> <p>Findings Include:</p> <p>1. Resident E's clinical record was reviewed on 6/19/14 at 1:00 p.m. Diagnoses included, but were not limited to, diabetes, chronic obstructive pulmonary disease, depression and heart failure. A review of Resident E's Minimum Data Set Assessment (MDS) indicated the resident had some mild cognitive impairment.</p> <p>During a review of "Concern/Grievance Log", provided by the interim Social Service Director on 6/19/14 at 10:45 a.m., a concern of "sexually inapp" (sexually inappropriate behavior) was noted.</p> <p>During an interview with the Director of Nursing (DoN) on 6/19/14 at 11:45 a.m., she indicated the sexually inappropriate comments occurred between Resident E and Resident D on the date of 6/2/14.</p> <p>Resident D's clinical record was reviewed</p>	F000250	<p>F 250 – 483.15(g)(1) – The facility will track the Behavior Management Program to monitor any resident s inappropriate behavior.</p> <p>A behavior monitoring log was initiated for the resident E during survey.</p> <p>Facility will review all residents to determine any residents who should have behavior monitoring logs initiated.</p> <p>Licensed staff will be re-educated on behavior monitoring documentation. Social Services/designee will monitor for adherence through review of behavior documentation a minimum of three times weekly. Further intervention will be taken as necessary.</p> <p>Result of audits will be forwarded to QA&A committee for tracking and trending monthly times 3 months then quarterly thereafter.</p>	07/16/2014			

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	<p>on 6/19/14 at 11:20 a.m. Diagnoses included, but were not limited to, debility, congestive heart failure and anxiety. A review of Resident D's Minimum Data Set Assessment (MDS) indicated the Resident was cognitively intact.</p> <p>During an interview with Resident D on 6/19/14 at 11:10 a.m., Resident D indicated Resident E was verbally sexually inappropriate with her. She indicated she did not report this, but she was very uncomfortable with Resident E's comments and "he is just a dirty old man". She indicated she was concerned for residents who could not defend themselves. Resident D indicated comments stated by Resident E towards her were "want to get in bed with me", "take off your clothes" and "want to play with each other t---". She indicate these comments always happened near the nurses station where the residents gathered She indicated Resident E always wanted to sit beside her.</p> <p>In a "Behavior Care Plan" provided by the Corporate nurse on 6/20/14 at 1:00 p.m., initiated on 3/28/14 and updated on 4/11/14, 6/2/14 and 6/19/14, Resident E was care planed for; depression with psychotic features, increased agitation, sexually and verbally abusive, yelling and</p>			

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	<p>screaming out, constant yelling, constant screaming, aggressive or threatening, confrontational, inappropriate sexual behavior and verbally abusive.</p> <p>Interventions for these behaviors were listed as: "provide reassurance, provide re-direction or diversion as needed, provide a structured and familiar daily routine, encourage to participate in activities of interest, explain procedures prior to implementation, encourage to make choices in activities of daily living (ADL's), provide time out during episodes of behavior, provide pain interventions needed, provide individual care/interests, encourage to express feelings, remove from situation when argumentative or combative-remove when exhibiting sexually inappropriate behaviors, psych services as ordered and ask resident to stop when being inappropriate.</p> <p>During an interview with the Corporate Nurse on 6/20/14 at 1:15 p.m., she indicated the facility did not have a full time Social Worker. A corporate social worker was assigned to the facility to assist until they hired a new full time social worker. She indicated they did not have monitoring logs for these behaviors which would show when the behaviors occurred or which interventions were</p>			

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F000312 SS=D	<p>used for which behavior. She indicated they had not been tracking Resident E's behaviors in this manner.</p> <p>No further information was provided.</p> <p>This Federal tag relates to Complaint IN00150283.</p> <p>3.1-34(a)</p> <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 ensure a resident who was dependent on staff for grooming and personal hygiene received those services in regards to oral care for 2 of 5 residents reviewed for assistance with oral care. (Resident F and J)</p> <p>Findings include:</p> <p>1. During an interview on 6/19/14 at 4:20 p.m., Resident (F) indicated staff did</p>	F000312	<p>F312 – 483.25(a)(3) The facility will ensure that residents who are dependent on staff for grooming and personal hygiene receive the proper services.</p> <p>Resident F and J received immediate oral care.</p> <p>The facility will review residents</p>	07/16/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155799		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/20/2014	
NAME OF PROVIDER OR SUPPLIER MARION REHABILITATION AND ASSISTED LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953			
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	<p>not provide assistance with oral care. She indicated she was dependent on staff for total care.</p> <p>During observation on 6/19/14 at 4:20 p.m., Resident (F)'s lips and mouth were dry/cracked with debris noted at the corners. During observation of Resident (F)'s bathroom, a sealed toothbrush and sealed box of toothpaste was noted on the sink.</p> <p>The clinical record of Resident (F) was reviewed on 6/20/14 at 9:00 a.m. Diagnoses for the resident included, but were not limited to, pressure ulcer to the coccyx, spina bifida, convulsions, chronic respiratory failure, chronic pain and diabetes mellitus. Resident (F) was admitted to the facility on 6/13/14.</p> <p>During observation on 6/20/14 at 8:50 a.m., Resident (F) was asleep in bed. The tooth paste and toothbrush were still sealed on the sink.</p> <p>During an interview on 6/20/14 at 4:20 p.m., the Director of Nursing (DoN) stated Resident (F) refused a lot of care. She indicated the resident had a special toothbrush and only allowed her mother to brush her teeth. She stated the resident did not yet have a care plan for ADL assist or refusing care. She indicated</p>		<p>who are dependent on staff for grooming to ensure oral care has been completed.</p> <p>Nursing staff will be re-educated on providing oral care to dependent residents. Interventions will be provided for residents refusing grooming and/or oral care. Monitoring for compliance will be done through assigned dept. managers visiting residents program referred to as "family".</p> <p>Result of audits will be forwarded to QA&A committee for tracking and trending monthly times 3 months then quarterly thereafter.</p>				

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NAME OF PROVIDER OR SUPPLIER MARION REHABILITATION AND ASSISTED LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953
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	<p>Resident (F) was dependent on staff for oral care. She indicated the oral care was not documented because it was part of the expected ADL care provided.</p> <p>During an interview on 6/20/14 at 1:30 p.m., CNA #1 indicated Resident (F) often refused care.</p> <p>During an interview on 6/20/14 at 1:35 p.m., CNA #2 indicated the staff used the oral swabs on Resident (F).</p> <p>During an interview on 6/20/14 at 3:30 p.m., Resident (F) indicated the staff do not use oral swabs for care.</p> <p>2. During an interview on 6/20/14 at 1:00 p.m., Resident (J) indicated he was dependent on staff for oral care. He stated he did not receive oral care twice daily. He indicated he had to have assistance to stand at the sink to brush his teeth.</p> <p>The clinical record of Resident (J) was reviewed on 6/20/14 at 3:00 p.m. Diagnoses included, but were not limited to, spinal stenosis, hypertension, anemia and aortic valve disease. Resident (J) was admitted to the facility on 8/30/13.</p> <p>The Admission Minimum Data Set (MDS) assessment, dated 5/22/14,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155799		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/20/2014	
NAME OF PROVIDER OR SUPPLIER MARION REHABILITATION AND ASSISTED LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953			
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F000314 SS=D	<p>indicated Resident (J) was cognitively intact.</p> <p>Review of the flow sheet for Activities of Daily Living (ADL), from 5/1/14 to 6/20/14, Resident (J) was provided routine showers, but oral care was not documented as having been provided.</p> <p>Review of a current care plan, dated 5/28/14, indicated Resident (J) had a problem with self-care deficit related to hemiparesis. Approaches to this problem included, but were not limited to, one person physical help with personal hygiene and one person physical help with bathing.</p> <p>This federal tag relates to Complaint IN00150283.</p> <p>3.1-38(a)(3)(C)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were</p>						

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NAME OF PROVIDER OR SUPPLIER MARION REHABILITATION AND ASSISTED LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953
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	<p>unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident with multiple pressure areas received proper skin treatments in accordance with her plan of care for 1 of 3 residents reviewed. (Resident F)</p> <p>Findings include:</p> <p>The clinical record of Resident (F) was reviewed on 6/20/14 at 9:00 a.m. Diagnoses for the resident included, but were not limited to, pressure ulcer to the coccyx, spina bifida, convulsions, chronic respiratory failure, chronic pain and diabetes mellitus. Resident (F) was admitted to the facility on 6/13/14.</p> <p>Resident (F) was observed on 6/19/14 at 8:50 a.m. on a low-loss air mattress.</p> <p>The initial pressure ulcer evaluation record, dated 6/14/14, indicated the first wound was noted on the right interior ankle. The wound measured 0.4 cm x 0.7 cm x 0.1. The wound was unstageable.</p> <p>The second wound was noted on the right interior knee. The wound measured 2.3 cm x 0.9 cm x 0.1 cm. The wound was</p>	F000314	<p>F314 - 483.25(c) The facility will ensure residents with multiple pressure areas receive proper skin treatments in accordance with their plan of care.</p> <p>Resident F's treatments were administered according to physicians orders.</p> <p>Facility will review all residents with pressure ulcers to comply with physicians orders.</p> <p>Licensed staff will be reeducated on completing dressing changes and providing proper skin care to residents with pressure ulcers.</p> <p>Monitoring for compliance will be done by the Director of Nursing/Designee through treatment record audits five times per week. Results of audits will be provided to QA&A Committee on a monthly basis for two months and then</p>	07/16/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155799	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER MARION REHABILITATION AND ASSISTED LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953		
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	<p>unstageable.</p> <p>The third wound was noted on the left interior knee. The wound measured 1.6 cm x 1.9 cm x .01 cm. The wound was unstageable.</p> <p>The fourth wound was noted on the left interior foot. The wound measured 2.8 cm x 2.5 cm. The wound was listed as a deep tissue injury.</p> <p>The fifth wound was noted on the left 5th inner aspect of the toe. The wound measured 0.8 cm x 0.5 cm x 0.1 cm. The wound was listed as a stage 3 pressure wound.</p> <p>The sixth wound was noted on the left great toe. The wound measured 2.0 cm x 1.0 cm. The wound was listed as a deep tissue injury.</p> <p>The seventh wound was noted to the right ischium. The wound measured 4.0 cm x 0.9 cm x 0.1 cm. The wound was a stage 4 pressure ulcer. The wound had a Jackson-Pratt drain in place.</p> <p>The physician order for treatment of the wound to the right ischium, dated 6/14/14, indicated the wound was to be cleaned with normal saline, patted dry and skin prep applied, then a calcium</p>		quarterly thereafter.		

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NAME OF PROVIDER OR SUPPLIER MARION REHABILITATION AND ASSISTED LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953		
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	<p>alginate dressing and the wound covered with hydrocolloid every 7 days and as needed.</p> <p>The wounds to the right interior knee, left interior knee and right interior ankle were to be cleaned with normal saline, patted dry and skin prep applied. The wounds were to covered with hydrocolloid dressing every 7 days and as needed.</p> <p>During review of the Medication Administration Record (MAR), provided by the Director of Nursing on 6/20/14 at 1:30 p.m., the record did not show any dressing changes for the noted wounds from 6/14/14 to 6/20/14.</p> <p>During an interview on 6/20/14 at 2:15 p.m., the wound nurse indicated she did not know why the MAR did not show who and when the wounds were treated. She indicated she was new to the facility and was still learning the documentation process.</p> <p>A current health care plan problem indicated an actual pressure ulcer. The interventions for the problem included, but were not limited to provide treatments as ordered.</p> <p>No additional information was provided related to dressing change dates and</p>				

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NAME OF PROVIDER OR SUPPLIER MARION REHABILITATION AND ASSISTED LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953		
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F000356 SS=C	<p>times.</p> <p>This federal tag relates to Complaint IN00150283.</p> <p>3.1-40(a)(2)</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to</p>				

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NAME OF PROVIDER OR SUPPLIER MARION REHABILITATION AND ASSISTED LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953			
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	<p>exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, interview, and record review, the facility failed to ensure posted nursing staff information for 2 of 2 days of the survey (6/19/14 and 6/20/14). This practice had the potential to affect 78 of 78 residents who resided in the facility.</p> <p>Findings include:</p> <p>During initial tour on 6/19/14 at 8:35 a.m., the nursing staff information was found not to be posted.</p> <p>During a second tour on 6/20/14 at 11:20 a.m., the nursing staff information was found not to be posted.</p> <p>During an interview on 6/20/14 at 11:35 a.m., the Director of Nursing indicated she did not know who was delegated to post the nurse staffing information.</p> <p>During an interview on 6/20/14 at 2:05 p.m., the interim Administrator indicated the facility had not posted nurse staffing information.</p>	F000356	<p>F356 – 483.30(e) – The facility will ensure nursing staffing information is posted in a public area as per regulation.</p> <p>No residents were directly impacted by the failure to post current staffing.</p> <p>Daily staffing will be posted in the facility lobby at the reception desk where it can be easily viewed by the general public.</p> <p>Daily staffing sheets will be placed in a display stand on a weekly basis by the Staffing Coordinator. Each day, the current staffing schedule will be brought forward and any staffing changes noted on the report.</p> <p>Monitoring for compliance will be accomplished by the</p>	07/16/2014			

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NAME OF PROVIDER OR SUPPLIER MARION REHABILITATION AND ASSISTED LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953			
(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			
F000516 SS=D	<p>483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public.</p> <p>The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>The facility must safeguard clinical record information against loss, destruction, or unauthorized use.</p> <p>Based on observation and interview, the facility failed to ensure residents' clinical records were stored to prevent against loss, destruction or unauthorized use.</p> <p>Findings include:</p> <p>During an initial tour of the Minimum Data Set (MDS) office with the MDS coordinator on 6/19/14 at 8:40 a.m., several residents' clinical records were observed stacked in piles on the floor and in cardboard boxes with two sprinklers overhead.</p> <p>During an interview with the MDS coordinator on 6/19/14 at 8:40 a.m., he</p>	F000516	<p>Executive Director</p> <p>on a daily basis.</p> <p>F516 – 483.75(I)(3). 483.20(f)(5) – The facility will ensure residents clinical records are stored to prevent against loss, destruction and unauthorized use.</p> <p>Facility had assigned a second person to wok on filing of confidential materials after they were in-serviced by the Medical Records Coordinator. The loose filing is being completed and older files are being inventoried and being boxed for storage and safe-keeping.</p>	07/16/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155799		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/20/2014	
NAME OF PROVIDER OR SUPPLIER MARION REHABILITATION AND ASSISTED LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953			
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	<p>indicated the MDS office filing cabinets contained residents' MDS and care plan clinical records. The MDS Coordinator indicated the facility was behind on breaking down charts do to a change in personal. He indicated it was a two person job and only one person was currently doing the task.</p> <p>During a tour of the clinical records storage room with LPN #3 on 6/19/14 at 9 a.m., nine boxes were observed directly on the floor or stacked on one another with seven of the nine containing discharged residents' clinical records. The clinical records were to be sent to an outside contracted storage facility and were observed to date back to 2012. Five of the seven filing cabinets with resident's clinical records were unlocked. Several residents' clinical record files were observed piled on top of the filing cabinets in the storage room and were observed to date back to May 2013. Two sprinklers were observed overhead.</p> <p>During an interview with LPN #3 on 6/19/14 at 9 a.m., she indicated the clinical records storage room did not have all of the residents' clinical records stored in filing cabinets. She indicated she was unable to catch up or maintain the storage of the residents' clinical records. LPN#3 indicated she had</p>		Monitoring for compliance will be accomplished through visits by the Medical Records Consultant and Administrator with any variance reported to the QA&A committee.				

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NAME OF PROVIDER OR SUPPLIER MARION REHABILITATION AND ASSISTED LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953
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	<p>multiple other tasks in the facility she was to complete along with the storage of clinical records.</p> <p>During an interview with the Interim Administrator on 6/20/14 at 4:35 p.m., he indicated he was aware the storage of clinical records was a problem.</p> <p>A review of the current August 2001 policy titled "LTC Health Information Practice and Documentation Guidelines" provided by the Nurse Consultant on 6/20/14 at 3:10 p.m. indicated the following:</p> <p>"File cabinets: ...The cabinets should be locked whenever the health information staff is not in the office...</p> <p>...4.5.3 Alternative Storage Areas: ...When an alternative storage space is needed, the space selected must be secure and must protect the records from damage, loss or destruction.</p> <p>Storage rooms must be organized allowing for ease in location and retrieval of records and documents. Similar documents should be retained together...</p> <p>...Storage boxes: ...When storage boxes are used, they should not be stacked on top of each other. Boxes should be</p>			

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NAME OF PROVIDER OR SUPPLIER MARION REHABILITATION AND ASSISTED LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953		
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R000000	<p>placed off the floor and below sprinkler heads following state fire safety standards. In absence of a standard, boxes should be at least 18" off of the floor and 18" below sprinkler heads."</p> <p>This federal tag relates to Complaint IN00150283.</p> <p>3.1-50(d)</p> <p>This visit was for the investigation of Complaints IN00150283 and IN00150564.</p> <p>Complaint # IN00150283 - Substantiated with related deficiency cited at R351.</p> <p>Complaint #IN00150564- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: June 19 & 20, 2014</p> <p>Facility number: 012809 Provider number: 155799 AIM number: 2011365580</p>	R000000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155799	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/20/2014
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NAME OF PROVIDER OR SUPPLIER MARION REHABILITATION AND ASSISTED LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953
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R000351	<p>Survey team: Shelley Reed, RN TC Jason Mench RN Angela Selleck RN</p> <p>Census bed type: Residential: 26 Total: 26</p> <p>Census payor type: Other: 26 Total: 26</p> <p>Sample: 2</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p> <p>410 IAC 16.2-5-8.1(c)(d) Clinical Records - Noncompliance (c) The facility must safeguard clinical record information against loss, destruction, or unauthorized use. (d) The facility must keep confidential all information contained in the resident ' s records, regardless of the form or storage method of the records, and release such records only as permitted by law. Based on observation and interview, the facility failed to ensure the residents' clinical records were stored to prevent against loss, destruction or unauthorized use.</p>	R000351	R351 – The facility will ensure the residents’ clinical records are stored to prevent against loss, destruction or unauthorized use.	07/16/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155799		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/20/2014	
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	<p>Findings include:</p> <p>During an initial tour of the Minimum Data Set (MDS) office with the MDS coordinator on 6/19/14 at 8:40 a.m., several residents' clinical records were observed stacked in piles on the floor and in boxes with two sprinklers overhead.</p> <p>During an interview with the MDS coordinator on 6/19/14 at 8:40 a.m., he indicated the MDS office filing cabinets contained residents' MDS and care plan clinical records. The MDS Coordinator indicated the facility was behind on breaking down charts do to a change in personal. He indicated it was a two person job and only one person was currently doing the task.</p> <p>During a tour of the clinical records storage room with LPN #3 on 6/19/14 at 9 a.m., nine boxes were observed directly on the floor or stacked on one another with seven of the nine with discharged residents' clinical records. The clinical records were to be sent to an outside contracted storage facility and were observed to date back to 2012. Five of the seven filing cabinets with residents' clinical records were unlocked. Several residents' clinical record files were observed piled on top of the filing cabinets in the storage room and were</p>		<p>No residents were impacted by this deficiency.</p> <p>Facility had assigned a second person to wok on filing of confidential materials after they were in-serviced by the Medical Records Coordinator. The loose filing is being completed and older files are being inventoried and being boxed for storage and safe-keeping.</p> <p>Monitoring for compliance will be accomplished through visits by the Medical Records Consultant and Administrator with any variance reported to the QA&A committee</p>				

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	<p>observed to date back to May 2013. Two sprinklers were observed overhead.</p> <p>During an interview with LPN #3 on 6/19/14 at 9 a.m., she indicated the clinical records storage room did not have all of the residents' clinical records stored in filing cabinets. She indicated she was unable to catch up or maintain the storage of the residents' clinical records. LPN#3 indicated she has multiple other tasks in the facility she was to complete along with the storage of clinical records.</p> <p>During an interview with the Interim Administrator on 6/20/14 at 4:35 p.m., he indicated he was aware the storage of clinical records was a problem.</p> <p>A review of the current August 2001 policy titled "LTC Health Information Practice and Documentation Guidelines" provided by the Nurse Consultant on 6/20/14 at 3:10 p.m. indicated the following:</p> <p>"File cabinets: ...The cabinets should be locked whenever the health information staff is not in the office...</p> <p>...4.5.3 Alternative Storage Areas: ...When an alternative storage space is needed, the space selected must be secure</p>						

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	<p>and must protect the records from damage, loss or destruction.</p> <p>Storage rooms must be organized allowing for ease in location and retrieval of records and documents. Similar documents should be retained together...</p> <p>...Storage boxes: ...When storage boxes are used, they should not be stacked on top of each other. Boxes should be placed off the floor and below sprinkler heads following state fire safety standards. In absence of a standard, boxes should be at least 18" off of the floor and 18" below sprinkler heads."</p> <p>3.1-50(d)</p>				