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 12/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION REHABILITATION AND ASSISTED LIVING CENTER	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
F000000	This visit was for the Investigation of Complaint IN00160710. Complaint IN00160710-Substantiated. Federal/State deficiencies related to the allegations are cited at F280 and F282. Survey dates: December 9 and 11, 2014 Facility number: 155799 Provider number: 012809 AIM number: 201136580 Survey team: Toni Maley, BSW Census bed type: SNF: 31 SNF/NF: 17 Total: 78 Census payor type: Medicare: 19 Medicaid: 17 Other: 42 Total: 78 Sample: 4 These deficiencies also reflect state findings cited in accordance with 410	F000000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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:	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155799	A. BUILDING 00 B. WING	12/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION REHABILITATION AND ASSISTED LIVING CENTER	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
	IAC 16.2-3.1. Quality review completed by Debora Barth, RN.			
F000280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on observation, interview and record review, the facility failed to review and update resident care plans and the computerized care plan tool used by staff to reflect physicians orders for 2 of 3 residents reviewed for care plans to address nutritional risk (Residents #B and #E).	F000280	**This Plan of Correction is Prepared and executed because The provision of State and Federal Law require it and not because Marion Rehabilitation & Assisted Living Center agrees with the Allegations made in the cited Deficiencies. The facility maintains That the alleged deficiencies do not Jeopardize**	12/23/2014

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 12/11/2014
NAME OF PROVIDER OR SUPPLIER MARION REHABILITATION AND ASSISTED LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953	

(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
	Findings include: 1. Resident #B's clinical record was reviewed on 12/11/14 at 10:00 a.m. Resident #B's current diagnoses included, but were not limited to, anxiety, hypothyroidism, dysphasia and unspecific protein calorie malnutrition. Resident #B had a current,11/26/14, physician's order for a mechanical soft diet. Resident #B had a current,11/26/14, physician's order for "resident requires supervision for all meals and assistance with feeding." Resident #B had a current,10/30/14, care plan problem/need regarding nutritional risk. Approaches to this problem, included but were not limited to, "serve mechanical soft diet." Resident #B had a current, 10/2/14, care plan problem/need regarding required assistance for activities of daily living. Approaches to this problem, included but were not limited to, "eating assistance required, with one person physical assistance." Resident #B had a current,11/20/14, 30 day Medicare, MDS (Minimum Data Set) assessment which indicated the resident received food by both a gastric tube and a mechanically altered diet. A 12/11/14, review of the"12/3/14 to present" written print out of the		**the health and safety Of guests, nor are they of such Character so as to limit our capability To render adequate care. The facility respectfully request A desk review/paper compliance of The allegations addressed in this POC. F280D: Resident E no longer resides At this facility. Resident B: physician Orders, care plan and electronic plan Of care system have been updated to Reflect this guest current diet Consistency and assistance needs. All current residents physician Orders, care plan and electronic plan Of care system have been updated to Reflect the guest current diet Consistency and assistance needs.. Licensed nurses will receive Education regarding updating the plan Of care with order changes to reflect The guest current status diet consistency And assistance needs. The DON/designee will audit New orders the next business day for Changes in diet consistency and/or Assistance needed to ensure the plan Of care is updated to reflect the Guest current status. Audits will be 3x/wk for 4 weeks then weekly for 3 Months and will be reviewed at the Monthly QA&A until a consistent**	

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 12/11/2014
NAME OF PROVIDER OR SUPPLIER MARION REHABILITATION AND ASSISTED LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953	

(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
	computerized vocal care tool indicated the resident "uses a feeding tube only" for meals. The computerized tool did not instruct direct care staff that Resident #B required a mechanical soft diet or supervision when eating. During a 12/11/14, 11:05 a.m., lunch observation, Resident #B was seated at a table in the main dining room with no nursing staff present. Resident #B was served a regular tossed salad with cherry tomatoes and croutons. Speech Therapist (ST) #24 arrived to supervise resident #B at 11:15 a.m. From 11:01 a.m. to 11:15 a.m., Resident #B was not supervised when dining. During a 12/11/14, 2:20 p.m., interview ST #24 indicated a regular tossed salad should not be served to a resident with a mechanical soft diet order. ST #24 additionally indicated she had been trialing Resident #B on salad when she supervised her meals. ST #24 also indicated Resident #B should not be served croutons and she had needed to remove them for the resident's safety. 2. Resident #E's closed clinical record was reviewed on 2/9/14 at 12:50 p.m. Resident #E's diagnoses included, but		**Pattern of compliance is achieved.**	

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 12/11/2014
NAME OF PROVIDER OR SUPPLIER MARION REHABILITATION AND ASSISTED LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953	

(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
	were not limited to, polycystic kidney disease, diverticulitis, depression and anemia. Resident #E had a,10/30/14, physician's order for "patient needs assistance with eating." Resident #E had a, 9/3/14, care plan problem/need regarding assistance for activities of daily living. Approaches to this problem, included but were not limited to,"eating independent." This care plan and approaches remained in place until the resident's death. The resident did not have a care plan or care plan approach which indicated the resident needed assistance to eat. A 12/11/14, review of the "10/9/14 to 11/13/14" written print out of the computerized vocal care tool indicated the resident needed "set up help only" and "self performance: independence" for eating. The computerized tool did not instruct direct care staff that Resident #E required assistance when eating. 3. During direct care staff interviews on 12/8/14 and 12/11/14, 10 CNAs were interviewed regarding how care staff identified care and services needed by each individual resident. 10 of 10 CNAs indicated the information to address each			

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 12/11/2014
NAME OF PROVIDER OR SUPPLIER MARION REHABILITATION AND ASSISTED LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953	

(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
	residents activity of daily living needs was listed in the computerized vocal care tool used by the facility staff (CNAs #2, #4, #6, #8, #12, #14, #15, #16, #18 and #22). During a 12/11/14, 3:00 p.m., interview, the Interim Director of Nursing indicated the information from each residents plan of care was on the computerized vocal care tool and accessed by direct care staff during care and services. She additionally indicated the tool reflected the approaches on each resident's care plans. Review of the 12/11/14, menu and portion size guide, which was provided by the Interim Administrator on 12/9/14 at 12:30 p.m., indicated a resident who received a mechanical soft diet could not have a regular tossed salad and was to be served a chopped salad instead. During a 12/11/14, 3:20 p.m., interview, the Interim Director of Nursing indicated the facility did not have a care plan and/or the computerized vocal care tool did not instruct Resident #B needed supervision when eating. She also indicated Resident #E had not had a care plan instructing staff to assist the resident			

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 12/11/2014
NAME OF PROVIDER OR SUPPLIER MARION REHABILITATION AND ASSISTED LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953	

(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
	to eat following the, 10/30/14, physician's orders. This Federal tag relates to Complaint IN00160710. 3.1-35(d)(2)(B)			
F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to follow physician's orders regarding diet orders and supervision when dining for 1 of 3 resident reviewed for following physician's orders for nutritional needs (Resident #B). Findings include: 1. Resident #B's clinical record was reviewed on 12/11/14 at 10:00 a.m. Resident #B's current diagnoses included, but were not limited to, anxiety, hypothyroidism, dysphasia and unspecific protein calorie malnutrition. Resident #B	F000282	**F282D: Resident B: physician orders** **Care plan and electronic plan of care** **System have been updated to reflect** **The guest current assistance needs.** **All current guests physician** **Orders, care plan and electronic plan** **Of care system have been updated to**	12/23/2014

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 12/11/2014
NAME OF PROVIDER OR SUPPLIER MARION REHABILITATION AND ASSISTED LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953	

(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
	had a current,11/26/14, physician's order for a mechanical soft diet. Resident #B had a current,11/26/14, physician's order for "resident requires supervision for all meals and assistance with feeding." Resident #B had a current, 10/30/14, care plan problem/need regarding nutritional risk. Approaches to this problem, included but were not limited to, "serve mechanical soft diet." Resident #B had a current, 10/2/14, care plan problem/need regarding required assistance for activities of daily living. Approaches to this problem, included but were not limited to, "eating assistance required, with one person physical assistance." Resident #B had a current, 11/20/14, 30 day Medicare, MDS (Minimum Data Set) assessment which indicated the resident received food by both a gastric tube and a mechanically altered diet. A 12/11/14, review of the "12/3/14 to present" written print out of the computerized vocal care tool indicated the resident "uses a feeding tube only" for meals. The computerized tool did not instruct direct care staff that Resident #B required a mechanical soft diet or supervision when eating. During a 12/11/14, 11:05 a.m., lunch		**Reflect the guest current assistance Needs.** **The electronic plan of care Has been updated to reflect the Guest assistance needs to alert and Communicate those needs to staff. Additionally a schedule has been Developed to provide nursing Oversight and assistance in the Dining area per the guests needs 3 meals/day 7 days/week.** **Audits will be performed By the Administrator/designee\ Randomly at various meal times 3x/ week for 4 weeks Then weekly for 3 months and will Be reviewed at the monthly QA&A Until consistent compliance is Achieved**	

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 12/11/2014
NAME OF PROVIDER OR SUPPLIER MARION REHABILITATION AND ASSISTED LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953	

(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
	observation, Resident #B was seated at a table in the main dining room with no nursing staff present. Resident #B was served a regular tossed salad with cherry tomatoes and croutons. Speech Therapist (ST) #24 arrived to supervise resident #B at 11:15 a.m. From 11:01 a.m. to 11:15 a.m., Resident #B was not supervised when dining. During a 12/11/14, 2:20 p.m., interview ST #24 indicated a regular tossed salad should not be served to a resident with a mechanical soft diet order. ST #24 additionally indicated she had been trialing Resident #B on salad when she supervised her meals. ST #24 also indicated Resident #B should not be served croutons and she had needed to remove them for the resident's safety. Review of the 12/11/14, menu and portion size guide, which was provided by the Interim Administrator on 12/9/14 at 12:30 p.m., indicated resident who received a mechanical soft diet could not have a regular tossed salad and were to be served a chopped salad instead. This Federal tag relates to Complaint IN00160710. 3.1-35(g)(2)			

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 12/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION REHABILITATION AND ASSISTED LIVING CENTER	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