

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  04/15/2015
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NAME OF PROVIDER OR SUPPLIER  MARKLE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 170 N TRACY ST MARKLE, IN 46770
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F 000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: April 9,10,13,14 and 15, 2015</p> <p>Facility number: 000544 Provider number: 155673 AIM number: 100267340</p> <p>Census bed type: SNF/NF: 74 Total: 74</p> <p>Census payor type: Medicare: 6 Medicaid: 54 Other: 14 Total: 74</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1</p>	F 000	<p>Credible 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>	
F 241 SS=D Bldg. 00	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's</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.

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	<p>dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review the facility failed to provide age appropriate items in an activity box for 1 of 2 residents (Resident #46) who met the criteria for dignity.</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #46 on 4/14/15 at 3:13 p.m., indicated the following: diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, and delusional disorder.</p> <p>An Activity Assessment for Resident #46, dated 6/27/14, indicated she participated in activities passively and actively. The assessment also indicated she liked to watch her peers and help staff, passively watched an activity more than actively participated, and needed encouragement and reminders of the activities.</p> <p>A Minimum Data Set assessment for Resident #46, dated 1/10/15, indicated severe cognitive impairment.</p> <p>Resident #46 was moved out of Auguste's Cottage (the memory care unit) on 4/3/15, since she was no longer an</p>	F 241	<p>F241I. Corrective Action Taken: It is the practice of this facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The items on the over bed table are no longer being placed in front of resident # 46. Resident's family interviewed to determine resident's interests &amp; a care plan developed. Resident #46's activity interests were reviewed by a member of the activity department. Age appropriate activity items were purchased by facility on 4/14/15 &amp; provided to resident #46 by the Activity Director. II. Identification of Other Residents: An audit was completed by a member of the IDT team on 5/1/15. The audit revealed no other residents were affected. An inservice was held for staff on the topic of Resident Rights. The inservice was conducted by the Clinical Education Coordinator &amp; completed by 5/11/15.III. Measures Put In Place: IDT will review activity care plans for all cognitively impaired residents, upon admission &amp; significant change to ensure activity care plan meets the resident's activity needs. Activity Director/designee will conduct daily rounds to ensure activity care plans are being followed.IV. Monitoring of</p>	05/11/2015			

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	<p>elopement risk and did not benefit from cottage programming.</p> <p>During an observation on 4/13/15 at 1:30 p.m., Resident #46 was observed seated in her wheelchair in the common area close to the nursing station and near the front entrance of the facility. An over-the-bed table was pulled up in front of her. On top of the over-the bed table was an activity box containing several toys designed for children - a plastic chain saw, a plastic wrench, a plastic block, and a plastic spinning top. Resident #46 was only observed to move the children's toys from one end of the table to the other.</p> <p>During an observation on 4/14/15 at 1:00 p.m., Resident #46 was observed seated in her wheelchair in the common area close to the nursing station and near the front entrance of the facility. An over-the bed table was pulled up in front of her. On top of the over-the-bed table was an activity box containing several toys designed for children - a plastic chain saw, a plastic wrench, a plastic block, a plastic spinning top, a plastic maraca, a plastic children's "Teenage Mutant Ninja Turtle" tambourine, and a small keyboard.</p> <p>During an observation on 4/14/15 at 4:02</p>		<p>Corrective Action Taken: A designated member of the IDT team will monitor compliance by completion of a CQI tool entitled "Activity Care Plan Compliance. The tool will be completed weekly x 4 weeks, then monthly x 6 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. Completion Date: 5/11/15</p>				

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	<p>p.m., Resident #46 was observed seated in her wheelchair in the common area close to the nurses station and near the entry to the facility. An over-the-bed table was pulled up in front of her. The same activity box containing the plastic children's toys was again on top of the over-the bed table. She was not observed interacting with the items.</p> <p>A facility care plan for Resident #46, with a review date of 4/14/15, indicated the problem area of resident doesn't understand an activity invitation to group activity. She is unable to self initiate an activity on her own. She will need set up of leisure pursuits. She will also need assisted to and from group activities and may need assistance with some activity. Past and observed activity interest: music, pet/animals, being around others, sensory groups, looking at magazines, holding a stuffed animal on occasions. Used to sell Avon. Approaches to the problem included, but were not limited to, assist during an activity as needed, assist resident to activity of potential interest and observe for signs of pleasure, offer resident items for leisure activities such as a stuffed animal, magazines, Avon books, sensory items, offer resident magazines and Avon books to look at, and stop by with visiting dogs.</p>			

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F 256 SS=D Bldg. 00	<p>Activities #3 was interviewed on 4/15/15 at 11:00 a.m. During the interview, she indicated the items in the activity box on the over-the-bed table for Resident #46 were not provided by her family, but were provided by the facility.</p> <p>The Administrator was interviewed on 4/15/15 at 11:40 a.m. During the interview, she indicated the items in the activity box on the over-the-bed table belonged to another resident and not Resident #46. When queried she did not know why the activity box had been placed in front of Resident #46 when she was seated in the common area.</p> <p>A current undated facility policy "Resident Rights", provided by Medical Records on 4/15/15 at 11:15 a.m., indicated "...The resident has a right to a dignified existence...A facility must protect and promote the rights of each resident..."</p> <p>3.1-3(t)</p> <p>483.15(h)(5) ADEQUATE &amp; COMFORTABLE LIGHTING LEVELS The facility must provide adequate and comfortable lighting levels in all areas. Based on observation and interview, the facility failed to ensure adequate lighting</p>	F 256	F256I. Corrective Action: It is the practice of this facility to provide adequate and comfortable lighting	05/11/2015			

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	<p>was provided for 3 residents in 3 resident rooms for 1 of 3 halls observed in the facility. (Resident #90, Resident #78, Resident #28)</p> <p>Findings include:</p> <p>On 4/9/15 at 1:54 p.m. Resident # 90 was observed in her room. She was observed to be in the bed closest to the door, farthest away from the window. She was observed to have her bed positioned in the room with the head of the bed in the corner of the room. The light positioned on the wall was not over the bed. A pull chain, which was used to activate the light, was hanging down the wall and was observed to be out of reach of the resident when she was in her recliner. The resident's recliner, which was observed to be a large, lift type chair, was positioned with the back of the recliner facing the wall with the light on it. An end type table was observed in the room with a lamp on it, which was positioned beside resident's chair.</p> <p>On 4/9/15 at 1:56 p.m. Resident #90 was interviewed in her room. She indicated there was not adequate light in her room. At the time, the light on the wall was activated by the pull chain and the only lights that illuminated were the lights</p>		<p>levels in all areas. Resident # 90: The light bulb was installed in the wall mounted light fixture. The end table with lamp was replaced with a floor lamp on 4/15/15. A longer pull chain was installed on resident's wall mount fixture &amp; resident can now reach it when sitting in recliner. Resident #78: The light switch was repaired on 4/15/15 &amp; all bulbs have been screwed back in the fixture. Brighter bulbs were installed in the wall light fixture &amp; ceiling light fixture. Resident #28: Brighter light bulbs have been installed in resident's wall light fixture and ceiling light fixture. II. Corrective Action Taken: All residents have the potential to be affected. All lights on 200 hall were checked by Maintenance to ensure lights are functioning properly and have adequate illumination. Staff will be re-educated by Clinical Education Coordinator and Maintenance Supervisor on the proper procedure for maintenance work orders. Education will take place by 5/11/15. In addition, Maintenance Supervisor will add this procedure to the Maintenance training portion of each New Hire Orientation. III. Measures Put In Place: Maintenance will replace all light bulbs in all resident rooms on 200 hall with brighter bulbs of a greater wattage. This will be completed by 5/11/15. Monitoring resident room light bulbs will be</p>		

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	<p>which directed light upward toward the ceiling. No downward facing light from the light fixture on the wall was observed. The resident indicated she brought in a lamp from home to use in her room but there was still not adequate light for her. At the time, the blinds in the room were closed. The resident indicated when her roommate was put to bed, they close the blinds in the room. Resident #90 indicated she would prefer them left open as it provides more light for her.</p> <p>On 4/10/15 at 10:30 a.m. an interview with Resident #28 was conducted. She indicated there was not adequate lighting in her room. She indicated the small light on the wall over the bed and the 1 light on the ceiling, which was located over the entry path into her room, did not provide adequate lighting for her.</p> <p>At 1:30 p.m. on 4/15/15: the Maintenance Supervisor was interviewed. He indicated he does not have a preventative maintenance program for monitoring resident's lights in their rooms. He indicated nursing lets him know if they find a light out by completing a work order for him. He also indicated that housekeeping tests the lights daily and let's him know if there is a light out. He indicated he was unaware</p>		<p>added to the Preventative Maintenance Program &amp; completed by the Maintenance Supervisor. Customer Care Representatives will check for proper light function during regular Customer Care Rounds &amp; will complete a maintenance work order when needed.IV. Monitoring of Corrective Action Taken: To ensure compliance, Maintenance Supervisor/designee will be responsible to complete a CQI tool weekly x 4 weeks, then monthly x 6 months. The results of these audits will be reviewed by the CQI committee overseen by the Administrator. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Completion Date: 5/11/15.</p>		

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	<p>of any lights that were not functioning.</p> <p>During the interview, the Maintenance Supervisor was made aware of the wall mounted light not working on 4/10/15 at 10 a.m. in Resident #78's room. At the time, there was observed to be a covered light fixture on the ceiling just inside the entry door to the room of Resident #78. The Maintenance Supervisor indicated the light on the ceiling was a distance of approximately 4 feet from the first bed and 10 feet from the second bed. The Maintenance Supervisor indicated the covered light over the door, had two 60 watt bulbs in it. He indicated the light fixture on the wall had two 60 watt bulbs that faced upwards and one 60 watt bulb that illuminated down. The Maintenance Supervisor indicated the "lighting in the room is not bright" and he has "even seen the staff lift up the front part of the light to get brighter, direct lighting." He indicated the reason Resident #90's downward facing light didn't illuminate was because it was burned out. He indicated he was unaware this light was not working properly.</p> <p>On 4/15/15 at 1:35 p.m. Resident #78's room was observed with the Maintenance Supervisor. The Maintenance Supervisor pulled the chain to activate the wall light and the light didn't work at all. He</p>			

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	<p>indicated the light needed a new switch. At the time, he opened the front of the light appliance. After reviewing the light bulbs, he indicated the light switch was stuck. He indicated the staff had unscrewed the light bulbs instead of letting him know to replace the light switch. He indicated this resident's light over the bed in the rooms "isn't real bright."</p> <p>On 4/15/15 at 1:44 p.m. Resident #90's room was observed with the Maintenance Supervisor. The end table, with the lamp place on it, was now located behind the resident's recliner, between her recliner and the wall. At 1:46 p.m. the Maintenance Supervisor was interviewed. He indicated the top of the lamp on the end table, located behind the resident's recliner, was about 3 feet fall. He indicated the back of the resident's recliner was about 4 feet tall. At the time, the light located on the wall was activated by the pull chain. The only light which illuminated, was the light coming out of the top of the light fixture and there was none from the bottom of the light fixture. The resident indicated she really could use more light in her room and the lamp she brought in from home, which was behind her chair and the light on the wall, did not provide adequate light.</p>			

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	<p>On 4/15/15 at 2:14 p.m. CNA (Certified Nurses Assistant) #30 was interviewed. She indicated if she was aware a resident's room light was not working properly, she told her charge nurse immediately.</p> <p>On 4/15/15 at 2:15 p.m. the Administrator was made aware of the condition of the over bed lights and resident's concerns with inadequate lighting. She indicated the facility had started replacing the overbed lights in the dementia unit and their plan was to replace one light every month.</p> <p>On 4/15/15 at 4 p.m. the Administrator was interviewed. She indicated the facility had only completed the replacement of wall mounted lights in one room on the dementia unit. She indicated she was unsure of the exact date but indicated the replacing of the overbed lights began in December 2014 on the dementia unit. She indicated the facility's intent was to replace lights in one room per month.</p> <p>3.1-19(dd)</p>				

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F 282 SS=D Bldg. 00	<p>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.</p> <p>Based on observation, interview and record review, the facility failed to ensure a plan of care was followed in regards to a resident with a tracheostomy having emergency supplies available for 1 of 1 resident (Resident #2) reviewed for a tracheostomy. The facility further failed to follow a care plan for eating/swallowing for 1 of 1 resident (Resident #87) reviewed for dysphagia (difficulty in swallowing).</p> <p>Findings include:</p> <p>1. On 4/10/15 at 10 a.m. the clinical record of Resident #2 was reviewed. The resident had been admitted to the facility on 10/8/14. Diagnoses included, but were not limited to the following: pulmonary congestion; obstructive sleep apnea, history of stroke, epilepsy, dysphagia, hemiplegia, heart disease and chronic airway obstruction.</p> <p>Physician orders, dated 4/1/15, included</p>	F 282	<p>F282I. Corrective Action Taken: It is the practice of this facility that services provided or arranged by the facility are provided by qualified persons in accordance with each resident's written plan of care. The care plans for Resident #87 &amp; Resident #2 have been updated and are being followed. An extra trach, an ambu bag, and the proper tubing were placed in resident # 2's room. Direct care staff were inserviced on the proper feeding of Resident #87. Inservice was conducted by Clinical Education Coordinator and was completed by 5/11/15.II. Identification of Other Residents: All residents with FIT/Restorative care plans have the potential to be affected. Direct care staff were educated regarding care plans. The inservice was conducted by the Clinical Education Coordinator &amp; completed by 5/11/15. A care plan audit on all FIT and Restorative nursing programs was performed by members of the IDT team to ensure care plans are individualized and include</p>	05/11/2015

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	<p>but were not limited to the following: start date for trach (tracheostomy) (a surgically created opening in the front of the neck, which connects to the windpipe, and maintained patent with a small plastic trach tube) orders was 10/8/14: "Trach orders: suction trach as needed for secretions..type/size of trach: Montgomery 10...trach care as needed...change...filter on suction machine...on first Friday of the Month...change suction canisters once a day on Mon (Monday), thu (Thursday). 10 p.m. - 6 a.m...routine trach care every shift, normal saline and peroxide to be used during trach care q (every) shift..."</p> <p>On 4/13/15 at 12:10 p.m. the resident was observed to have a trach in place.</p> <p>A care plan which addressed the problem of "(Resident #2 name) is at risk for respiratory distress r/t (related to) COPD (chronic obstructive pulmonary disease) and tracheostomy." The goal date was 4/18/15. The approaches included, but were not limited to the following: wears trach; assess respiratory status at least every shift and prn for congestion, cyanosis (bluish skin tone due to lack of oxygen), labored respirations...observe for congestion and suction as needed...perform trach care as ordered. Change trach per order...keep extra trach</p>		<p>measurable goals and resident specific interventions. Audit was completed by 5/11/15. There are no other trach residents currently residing at the facility.III. Measures Put In Place: Direct care staff were educated regarding checking for emergency trach supplies &amp; the proper feeding of Resident #87. The inservice was conducted by the Clinical Education Coordinator &amp; was completed by 5/11/15. A trach supply checklist has been implemented and will be completed by the 3rd shift nurse each day for each resident who uses a trach. The checklist will be kept in the 24 Hour Report book for each hall where a resident with a trach resides. Extra trach supplies will be ordered by central supply and kept in storage for when needed. Upon discharge from therapy, the attending therapist will update the restorative/FIT program for each resident on a restorative/FIT program. Updated programs will be completed by the therapist on the day of discharge from therapy. In the weekly Medicare meetings, the Rehab Services Manager will notify the Medicare team of all residents who will be discharged from therapy caseload. At this time, resident's care plan will be reviewed &amp; updated for appropriate restorative/FIT program. The dining room manager/nurse manager will observe those</p>				

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	<p>at bedside. Keep Ambu (air mask bag unit) at bedside; Resident may remove trach as desired and keep at bedside.</p> <p>On 4/14/15 at 10:44 a.m. the LPN #33 was observed to perform trach care for Resident #2. In the process of the trach care, the resident was observed to cough and produce phlegm from the trach site and LPN #33 was able to wipe the phlegm from the tracheostomy site. The resident was able to clear his airway independently. LPN #33 was observed to assist the resident in cleansing the trach site of phlegm by wiping it away with gauze.</p> <p>On 4/14/15 at 3 p.m. LPN #31 was interviewed. She indicated the suction machine was housed on the crash cart, which was located on another hall in the facility away from where Resident #2 resided. At the time, the closet in the resident's room was opened and a suction machine was observed. LPN #31 attempted to demonstrate how to assemble the suction machine and suction tubing together for use. LPN #31 was unable to locate suction tubing in the resident's room which would attach to the end of the connective tubing and actually be used to suction the resident down the tracheostomy site. The only tubing LPN #31 was able to locate in the resident's</p>		<p>residents who have Fit/Restorative care plans &amp; ensure the care plan is being followed. This observation will be monitored each meal and recorded on a log. IV. Monitoring of Corrective Action Taken: MDS/MDS assistant will monitor compliance by completion of a CQI tool for the Care Plans of the Restorative/FIT programs. The tool will be completed weekly x 4 weeks, then monthly x 6 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. Completion Date: 5/11/15</p>	

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	<p>room were 3 "non-conductive suction tube connections." LPN #31 was also unable to locate an extra trach in the resident's room. LPN #31 indicated the suction tubing catheter would be located in the facility crash cart.</p> <p>On 4/14/15 at 3:10 p.m. LPN #31 was observed to go to the crash cart located in another hall of the facility. When interviewed regarding location of a suction catheter for the tracheostomy, she produced a Yankaur (a hard plastic preformed wand type suction device) suction tip from the crash cart.</p> <p>At 3:20 p.m. on 4/14/15 the Director of Nursing was interviewed. She indicated they have a spare trach for Resident #2 and it was on her desk. She indicated staff had just now placed the trach in the resident's drawer in his room. The DON indicated the extra trach and/or suction tubing should either be in the resident's room and /or the medication cart, which is either outside in the hall or close by at the nurses ' station. She indicated the resident had recently coughed out the trach tube and they had a difficult time finding a replacement as the resident has had the trach for such a long time. The DON indicated the resident has had the trach for at least 20 years.</p>			

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	<p>On 4/15/15 at 1:55 p.m. the DON was interviewed. She indicated the resident should have the spare trach tube and an Ambu bag kept in the resident's room and indicated by the care plan.</p> <p>2. Review of the clinical record for Resident #87 on 4/13/15 at 3:17 p.m., indicated the following: diagnoses included, but were not limited to, profound intellectual disabilities, periodontal disease, and salivary secretion disturbance.</p> <p>A physician's order for Resident #87, dated 6/3/14, indicated a Mechanical Soft diet with large portions.</p> <p>A New Order Documentation/Temporary Care Plan for Resident #87, dated 6/20/14, indicated he was discharged from Speech Therapy and would begin Speech Therapy 3 x (times) a week for dysphagia treatment.</p> <p>A Restorative FIT (Functional Independent Therapy Treatment) Referral/Recommendations for Resident #87, dated 6/18/14 and completed by the Speech Language Pathologist, indicated he consumed a Mechanical Soft diet with thin liquids via a sippy cup with minimal signs/symptoms of aspiration/penetration. The report also indicated he required</p>				

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	<p>set-up with meals, all food to be cut into small pieces, and verbal cues to eat slowly. Equipment required included a plate guard, a sippy cup, Mechanical Soft foods, and thin liquids. The report further indicated Resident #87 displayed poor safety awareness while eating increasing his risk of choking.</p> <p>A New Order Documentation/Temporary Care Plan for Resident #87, dated 6/20/14, indicated he was discharged from dysphagia treatment.</p> <p>A Speech Therapist Progress &amp; Discharge Summary for Resident #87, dated 6/20/14, indicated he demonstrated the ability to safely swallow 1/2 tsp of Mechanical Soft diet using compensatory strategies from trained staff or caregivers given 50% verbal cue to ensure safety of intake with no outward signs/symptoms of aspiration/penetration. The summary also indicated he was seen by skilled speech therapy for oropharyngeal (oral cavity/upper esophagus) dysphagia. The summary further indicated he was currently tolerating a Mechanical Soft diet and thin liquids via a free flow cup. Resident #87 required moderate assistance with meals to ensure safety of intake. The summary also indicated a Restorative Nursing Program was recommended with no further Speech</p>			

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	<p>Therapy.</p> <p>A FIT Program Flowsheet for Resident #87, with a start date of 7/1/14 and open ended, indicated the eating/swallowing program of resident will feed self at least 75% of 3 meals daily and be free from signs/symptoms of aspiration daily TID (three times a day). The program did not include the additional recommendations made by the Speech Therapist.</p> <p>A New Order Documentation/Temporary Care Plan for Resident #87, dated 8/5/14, indicated to discontinue the 2 handle sippy cups with all meals due to regular cups preferred.</p> <p>A discharge Dental report for Resident #87, dated 9/17/15, indicated multiple dental extractions of his remaining teeth. The report indicated the discharge diet of Pureed with thickened liquids.</p> <p>A physician's order for Resident #87, dated 9/18/14, indicated a Pureed diet with honey thickened liquids and on 9/24/14 a physician's order indicated to progress his diet to Mechanical Soft. A divided plate and a plate guard were to be used for all meals.</p> <p>A Speech Therapy Screen for Resident #87, dated 4/7/15, indicated he received a</p>			

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	<p>Mechanical Soft diet with thin liquids. The screen also indicated the areas of no loss of liquids/solids from mouth when eating or drinking and no coughing or choking during meals or when swallowing medications were marked not applicable. The screen further indicated for Speech Therapy to evaluate and treat as indicated.</p> <p>An Annual Review Progress Note for Resident #87, dated 4/8/15, indicated he continued on a Mechanical Soft diet. The note also indicated he continued to eat quick with his hands and filled his mouth with food.</p> <p>A facility care plan for Resident #87, with a review date of 2/11/15, indicated the problem area of resident requires eating/swallowing program to decrease the risk of aspiration. Interventions to the problem included, but were not limited to, specialized drinking cup, hands on support, resident may use straws, task segmentation, verbal prompts to chin tuck, alternate liquids and solids, chew thoroughly, take smaller bites, and observe for signs of aspiration, coughing, sneezing, tearing, runny nose, or gurgling voice.</p> <p>A facility care plan for Resident #87, with the review date of 2/11/15, indicated</p>			

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	<p>the problem area of resident eats fast and requires a mechanically altered diet. Interventions to the problem included, but were not limited to, provide Mechanical Soft diet, plate guard and divided plate at all meals, and observe for signs/symptoms of difficulty chewing/swallowing with current diet consistency.</p> <p>During an observation of the lunch meal in the main dining room on 4/9/15 at 12:11 p.m., Resident #87 was observed seated in his wheelchair at a dining room table. A glass of ice water was at his place setting. He was observed to take large gulps of water losing some of the water from his mouth, due to poor lip closure around the rim of the glass. He was observed to cough several times after drinking the ice water. His lunch meal of a ground Western burger on a bun, wedge fries, marinated cucumbers, and apricots was served in a divided plate with a plate guard. The staff who delivered his plate was observed to cut his sandwich in half, but did not cut the sandwich and other foods into small pieces. He was observed to eat at a very fast pace, shoveling a large amount of food into his mouth with either a spoon or his fingers. As he was eating he lost a portion of the food he placed in his mouth due to poor lip closure. Throughout the meal he was</p>			

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	<p>observed to forcefully cough when eating and drinking resulting in liquid and food being expelling from his mouth. Staff were not observed to encourage him to slow his rate of eating, to take small bites, or to alternate bites of food with sips of liquid.</p> <p>During an observation of the lunch meal on 4/13/15 at 11:48 a.m., Resident #87 was observed seated in his wheelchair at a dining room table. His lunch meal of a ground fish sandwich with cheese on a bun, potato triangle, cooked carrots, and applesauce was served in a divided plate with a plate guard. The staff who delivered his plate was observed to cut his sandwich in half but was not observed to cut the sandwich and other foods into small pieces. He was observed to eat at a very fast pace, shoveling a large amount of food into his mouth with either a spoon or his fingers. As he was eating he lost a portion of the food he placed in his mouth due to poor lip closure. Coughing was noted while he was eating his food. He was observed to finish his meal before drinking any of his liquids. He was observed to take large gulps of the liquids losing some of the water from his mouth due to poor lip closure around the rim of the glass. His coughing was forceful resulting in food and liquids being expelled from his mouth. Staff</p>			

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	<p>were not observed to encourage him to slow his rate of eating, to take small bites, or to alternate bites of food with sips of liquid.</p> <p>During an observation of the breakfast meal on 4/14/15 at 8:28 a.m., Resident #87 was observed seated in his wheelchair at a dining room table. He had completed his breakfast meal and was observed drinking his liquids. He was observed to take large gulps of the liquids losing some of the liquid from his mouth due to poor lip closure around the rim of the glass. He was observed to cough while drinking his liquids. His clothing protector was observed to be wet from his liquids and contained large pieces of food which had fallen from his mouth.</p> <p>Certified Nursing Assistant #1 was interviewed on 4/14/15 at 8:30 a.m. During the interview she indicated Resident #87 usually coughed during meals. She also indicated it varied from day to day on how much he coughed.</p> <p>Speech Therapist #2 was interviewed on 4/15/15 at 8:56 a.m. During the interview she indicated Resident #87 had been on a Pureed diet, but then refused to eat the pureed consistency and lost weight. His diet was upgraded to</p>			

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	<p>Mechanical Soft and a swallowing program was developed. She also indicated his lip closure during drinking was much better with the sippy cup, but it was changed to a regular glass due to his preference. She acknowledged Resident #87 ate too quickly, placed too much food into his mouth, and coughed while eating. She further indicated the swallowing program should be followed to keep him safe while dining. She also indicated staff were to notify her in person or through a screening form of any coughing or choking during dining. She further indicated she had recently picked up Resident #87 for speech therapy again due to his increased verbalizations.</p> <p>A current facility policy "IDT (Interdisciplinary Team) Care Plan Review" with a revision date of 4/2014 and provided by the Director of Nursing Services on 4/15/15 at 11:57 a.m., indicated "...It is the policy...that each resident will have a comprehensive care plan developed based on comprehensive assessment. The care plan will include measurable goals and resident specific interventions based on resident needs and preferences to promote the residents highest level of functioning including medical, nursing, mental and psychosocial needs...."</p>			

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F 431 SS=E Bldg. 00	<p>3.1-35(g)(2)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p>			
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	<p>Based on observation, interview and record review the facility failed to ensure over the counter (OTC) medications, treatment creams/lotions/cleansers and an unidentified substance were properly labeled, and a vial of insulin was stored properly for 2 of 3 medication carts (200 Hall and Auguste's Cottage). Furthermore the facility failed to ensure 1 of 3 medication carts were maintained in a clean manner. (Auguste's Cottage)</p> <p>Findings include:</p> <p>1. On 4/13/15 at 10:15 a.m., the 200 hall med cart was observed with LPN #30. The following OTC (over the counter) medications had no physician name documented on the opened medication bottle: Tylenol 500 mg tablets (tabs), Multiple vitamin (MVI) tablets, Colace 100 mg tablets, Tylenol 325 mg tablets, Benadryl 25 mg tabs, Bisacodyl 5 mg tabs, Calcium 600 mg with Vitamin D3 800 International Units (IU) tabs, MVI tabs, Iron tabs 325 mg, Zyrtec 10 mg tabs, Aspirin 81 mg tabs and Gummy MVI chews.</p> <p>On 4/13/15 at 10:20 a.m., an observation of the treatment cart drawer included an unlabeled bottle, which contained a bright green gel like substance. There</p>	F 431	<p>F4311. Correction Action Taken: It is the policy of this facility to ensure drugs and biological used in the facility are labeled in accordance with currently accepted professional principles. All improperly labeled items were re-labeled according to policy. The pill fragment and pill residue were cleaned from the medication cart. Unidentified items were discarded. The insulin was discarded. The Sunblock was discarded. The Skintegritry Wound Cleanser was discarded. The Dermal Wound Cleanser was discarded. The dandruff shampoo was discarded. II. Identification of Other Residents: All residents have the potential to be affected. Nurses were educated on labeling of medications and over the counter items, proper storage of insulin, &amp; cart cleanliness. The inservice was directed by the Clinical Education Coordinator &amp; completed by 5/11/15. All medication and treatment carts were inspected by nursing management by 5/11/15 and corrections made if indicated. III. Measures Put In Place: A medication/treatment checklist has been implemented. The nurse on each hall is now responsible to inspect the medication &amp; treatment carts each day on each shift. The nurse will then immediately correct any areas of concern. The checklist will be kept on each</p>	05/11/2015			

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	<p>was no labeling, resident name, physician name and/or open date on the bottle of unidentified substance. At the time, LPN #30 opened the bottle and smelled the contents. She indicated she thought it smelled like (name of topical heat rub) but was not sure. At the time, LPN #30 disposed of the unlabeled bottle of unidentifiable green gel.</p> <p>On 4/15/15 at 11 a.m., the DON (Director of Nursing) was interviewed. She indicated the unlabeled, unidentifiable bottle of green substance found in the 200 hall medication cart should have been labeled and dated with appropriate information. She also indicated the OTC medications should have been labeled with the resident and physician name.</p> <p>2. During an observation of the medication and treatment cart in Auguste's Cottage, the memory unit, with LPN (Licensed Practical Nurse) #4 on 4/13/15 at 10:30 a.m., the following was observed: an unopened vial of Novolog insulin was stored in the medication cart.</p> <p>An interview on 4/13/14 at 10:30 a.m. with LPN #4 indicated the Novolog Insulin vial was not opened.</p> <p>During further observation of the medication and treatment cart in Auguste's Cottage with LPN #4 on</p>		<p>med cart &amp; forwarded to the Clinical Education Coordinator/ADNS at the end of each month to review for any areas of non-compliance &amp; follow-up education if indicated.IV. Monitoring of Corrective Action Taken: The ADNS/CEC will monitor compliance by inspecting the medications and biological products housed in the medication and treatment carts &amp; by completing a CQI tool. CQI tool will be completed weekly x 4, and then monthly x 6 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. Completion Date: 5/11/15.</p>		

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	<p>4/13/15 at 10:32 a.m., the following was observed: the bottom of the 2nd drawer contained 1/2 of an unidentified white pill and crushed pill residue was along the back of the drawer.</p> <p>An interview with LPN #4 on 4/13/15 at 10:32 a.m. indicated the night shift nurse was responsible to clean the medication carts and further indicated she did not know when the cart was last cleaned.</p> <p>On 4/13/15 at 10:35 a.m., during an observation of the medication and treatment cart in Auguste's Cottage with LPN #4, the following was observed: an opened OTC bottle of D3 (a vitamin) 1000 IU (International Unit) was not labeled with a resident's name or a physician's name; an opened OTC bottle of Aspirin 81 mg (milligrams) was labeled with a resident's 1st name, the aspirin bottle was not labeled with the resident's last name or a physician's name; an opened OTC bottle of Daily Multiple Vitamin for Men was labeled with a resident's 1st name, the bottle of multiple vitamins was not labeled with the resident's last name or a physician's name; an opened OTC bottle of Folic Acid 800 mg was labeled with a resident's 1st name, the bottle of folic acid was not labeled with the resident's last name or the physician's name; an</p>			

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NAME OF PROVIDER OR SUPPLIER  MARKLE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 170 N TRACY ST MARKLE, IN 46770
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	<p>opened OTC bottle of D3 1000 IU was labeled with a resident's 1st name, the bottle of D3 was not labeled with the resident's last name or a physician's name.</p> <p>An interview with LPN #4 on 4/13/15 at 10:35 a.m., indicated the OTC medications belonged to a resident who was recently admitted to the facility but was currently in the hospital. She further indicated the OTC medication bottles should have been labeled with the resident's name and the physician's name.</p> <p>An observation of the Treatment drawer in the medication cart for Auguste's Cottage with LPN #4 on 4/13/15 at 10:36 a.m., the following was observed: an opened 8 oz. (ounce) tube of [Brand] Sunblock Lotion was not labeled with an opened date or a physician's name; an opened 16 oz. spray bottle of Skintegritiy Wound Cleanser was not labeled with a resident's name, an opened date or a physician's name; an opened 8 oz. spray bottle of Dermal Wound Cleanser was not labeled with a resident's name, an opened date or a physician's name; an opened 6.8 oz. bottle of Dandruff Shampoo was not labeled with an opened date or a physician's name.</p> <p>An interview with LPN #4 on 4/13/15 at</p>			

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	<p>10:36 a.m., indicated she did not know which residents the wound cleanser sprays belonged too. She indicated there were no residents receiving wound care currently. She indicated the wound cleanser spray should have been labeled with a specific resident's name and a physician's name. She indicated the wound cleanser sprays would be discarded.</p> <p>An interview with the DON (Director of Nursing) on 4/13/15 at 4:32 p.m., indicated she had begun to educated the nursing staff to label the OTC medications with the resident's name, the physician's name, opened date and administration instructions. She further indicated the medication carts were to be cleaned every shift.</p> <p>An interview with LPN #4 on 4/14/15 at 1:00 p.m. indicated the unopened insulin was no longer on the medication cart since the resident's blood sugar level was only checked monthly.</p> <p>An interview with the DON on 4/15/15 at 10:55 a.m., indicated unopened insulin should be stored in the refrigerator until it was opened and indicated the insulin would be discarded if not stored properly.</p> <p>A review of the current facility's policy,</p>						

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	<p>provided by the DON on 4/15/15 at 11:57 a.m., titled, Medication Storage Requirements, with a revision date of 2-2014, indicated, "...To ensure drugs and biologicals are stored in a safe and secure manner in accordance to all manufacturer's recommendations and State and Federal laws, rules and regulations....The medicine preparation area is to be maintained by nursing staff in a clean and organized manner..."</p> <p>A review of the current facility's policy, provided by the DON on 4/15/15 at 11:57 a.m., titled, Labeling of Medications, with a revision date of 2-2014, indicated, "...All non-prescription (OTC) or vitamin supplements supplied by the resident or resident's family must bear a label which contains the following information:... Resident name...Prescriber's name...Original manufacturer's label containing, Product name and strength, expiration date and quantity...."</p> <p>A review of the facility's Pharmacy guide. provided by the DON on 4/15/15 at 3:22 p.m., titled, Medications Requiring Special Storage, dated 4/2011, indicated, "...Novolog...Refrigerate Prior to Opening...Expires 28 days after opening...Expires 28 days after removing from refrigerator opened or unopened...."</p>			

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F 520 SS=E Bldg. 00	<p>3.1-25(j) 3.1-25(l)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, interview and record review, the facility Quality Assessment and Assurance Committee failed to implement an action plan for the identified concerns regarding ensuring resident's dignity by providing age appropriate activity items, ensuring adequate lighting in residents' rooms, assuring care plans were followed for</p>	F 520	F520I. Corrective Action Taken:It is the policy of this facility to ensure the quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality	05/11/2015			

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	<p>eating and swallowing, ensuring tracheostomy supplies were available in a resident's room in accordance with the plan of care and ensuring clean medication carts, properly labeled OTC medications and treatment creams/lotions/cleansers were properly labeled with a resident's name and/or a physician's name and/or opened date, ensuring an unidentifiable substance was labeled with a manufacture's label, a resident's name, a physician's name and opened date, and ensuring unopened insulin was properly stored in the refrigerator.</p> <p>Findings include:</p> <p>The CQI (Continuous Quality Improvement) committee, consisted of the Administrator, the DON (Director of Nursing), ADON (Assistant Director of Nursing) the Medical Director and the Managers of each of the Facility's Departments met monthly and they failed to identify and to implement an action plan to correct and monitor the following: ensuring resident's dignity by providing age appropriate activity items, ensuring adequate lighting in residents' rooms, assuring care plans were followed for eating and swallowing, ensuring tracheostomy supplies were available in a resident's room in accordance with the</p>		<p>deficiencies.Action plans were developed for the following,-identifying concerns regarding the provision of resident's dignity by providing age appropriate activity items-ensuring adequate lighting is in resident rooms-ensuring care plans are followed for eating &amp; swallowing-ensuring trach supplies are available in resident's room in accordance with the plan of care-ensuring medication carts are clean--ensuring OTC medications and treatment creams/lotions/cleansers are properly labeled with a resident's name, physician's name and date opened-ensuring unidentifiable substances are identified by a manufacturer's label, resident's name, physician's name and date opened-ensuring unopened insulin is properly stored in the refrigeratorII. Identification of Other Residents:All residents who reside in the facility have the potential to be affected by the alleged deficient practice. Action Plans were developed for the above mentioned areas of concern and the action plans have been implemented. No other areas were identified that action plans need to be developed for.III. Measures Put in Place:Executive Director/Designee will inservice all building managers by 5/11/15 on implementing and following the Quality Assurance process for</p>				

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	<p>plan of care and ensuring clean medication carts, properly labeled OTC medications and treatment creams/lotions/cleansers were properly labeled with a resident's name and/or a physician's name and/or opened date, ensuring an unidentifiable substance was labeled with a manufacture's label, a resident's name, a physician's name and opened date, and ensuring unopened insulin was properly stored in the refrigerator.</p> <p>An interview with the Administrator on 4/15/15 at 3:30 p.m., indicated the CQI committee met monthly and the committee was not aware of these identified concerns. The Administrator indicated she was aware of the inadequate lighting in some resident's rooms but it was not part of the facility's QAA process yet. She further indicated the CQI committee will develop action plans for the identified concerns.</p> <p>3.1-52(a)(2)</p>		<p>any areas needing follow-up during C.Q.I. meetings. Monthly, the C.Q.I. committee will review concerns voiced during the monthly Resident Council Meetings, the monthly Grievance Logs, and the concerns received from Customer Care Representatives. The C.Q.I. committee will then determine the need for action plans for these additional areas. The Quality Assurance committee will be scheduled to meet monthly by the Executive Director/designee with all appropriate Q.A. members attending and audits will be completed. IV. Monitoring of Corrective Action: Executive Director will monitor by reviewing all action plans developed monthly for identified areas needing follow up &amp; to ensure it is implemented. The Quality Assurance meeting CQI audit tool will be reviewed monthly by the CQI Committee with audits being completed one x weekly for one month and monthly x 6 months by the DNS/designee after which the CQI committee will re-evaluate the need for continuance. Completion Date: 5/11/15</p>		