

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  04/07/2014
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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 Complaint IN00146653.</p> <p>This visit resulted in a partially extended survey - 2 Immediate Jeopardies</p> <p>Complaint IN00146653 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282, F312, F314, F333, F441 and F9999.</p> <p>Survey dates: March 2, 3, 4, 5, 6 and 7, 2014</p> <p>Facility number: 012809 Provider number: 155799 AIM number: 2011265580</p> <p>Survey team: Shelley Reed, RN TC</p> <p>Census bed type: SNF: 37 SNF/NF: 8 Residential: 29 Total: 74</p> <p>Census payor type: Medicare: 26 Medicaid: 8 Other: 40 Total: 74</p>	F000000	<p>This Plan of Correction is prepared and executed because the provision of State and Federal law require it and not because Marion Rehabilitation &amp; Assisted Living Center agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not jeopardize the health and safety of residents, nor are they of such character so as to limit our capability to render adequate care.</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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F000312 SS=D	<p>Sample: 8</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Debora Barth, RN.</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 record review and interview, the facility failed to ensure a resident who was dependent on staff for grooming and personal hygiene received those services in regards to a shower/complete bed bath and/or tub bath twice weekly for 1 of 4 residents reviewed for assistance with activities of daily living in a sample of 4. (Resident C)</p> <p>Findings include:</p> <p>The closed clinical record for Resident (C) was reviewed on 4/2/14 at 10:45 a.m. Diagnoses for the resident included, but</p>	F000312	<p><b>F312</b></p> <ol style="list-style-type: none"> <li>1. Resident C has been discharged from the facility.</li> <li>2. Facility to audit all guests to ensure showers are being given as per plan of care.</li> <li>3. Nursing staff to be re-educated on giving resident showers as per plan of care.</li> <li>4. DON/designee will monitor showers are being given and documented through CNA documentation audits 5 x week x 2 weeks, 3 weeks x 2 weeks then weekly for 1 month. The audits will be reviewed and monitored through QA monthly.</li> <li>5. To be completed by 4/29/14.</li> </ol>	04/29/2014

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	<p>were not limited to, left knee replacement, rheumatoid arthritis, fibromyalgia and hypertension.</p> <p>Review of a current health care plan problem/need, dated 1/11/14, indicated the resident had a self-care deficit related to left knee replacement. Interventions for this problem included, but were not limited to, supervision with toilet use, supervision with ambulation and one person physical assist with bathing. The resident requested showers at least twice per week and with a bed bath as needed.</p> <p>Another problem indicated the resident was a fall risk related to an unsteady gait, pain, and recent left knee replacement. The interventions for this problem included: provide adequate lighting, observe for side effect of medication and keep call light in reach. No additional interventions were listed.</p> <p>The most recent Minimum Data Set (MDS) assessment, dated 1/17/14, indicated Resident (C) was cognitively intact. Resident (C) received the following Activities of Daily Living (ADL) assistance. Transfer-extensive assist with one person assist, toilet-extensive assist with one person assist, dressing, eating and hygiene-independent with supervision.</p>			

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F000314 SS=J	<p>Review of the occupation therapy plan of care, dated 1/12/14, as the initial assessment, indicated Resident (C) required minimal assistance with toileting, moderate assistance with lower body dressing, moderate assistance with bathing and contact guard for transfer to shower and toilet.</p> <p>Review of bathing documentation provided by the Corporate Nurse on 4/3/14 at 12:15 p.m., indicated a bed bath was provided on 1/16/14. Resident (C) was in the facility 9 days.</p> <p>During an interview on 4/3/14 at 12:14 p.m., the Corporate Nurse indicated no additional showers sheets were found and was unsure why the resident was listed as only having 1 bed bath during her stay.</p> <p>This Federal tag relates to Complaint IN00146653.</p> <p>3.1-38(a)(2)(A)</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</p>						

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	<p>pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were 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>A. Based on observation, interview and record review, the facility failed to prevent the development of a pressure ulcer, resulting in a stage 2 pressure ulcer which progressed to a stage 4 ulcer for 1 of 3 residents reviewed (Resident G). B. The facility also failed to ensure a resident with multiple pressure areas received proper skin treatments in accordance with his plan of care for 1 of 3 residents reviewed (Resident I).</p> <p>This deficient practice resulted in Immediate Jeopardy. This Immediate Jeopardy began on 3/22/14 when the facility failed to identify a resident with a stage 2 pressure area to her coccyx, which quickly progressed to a stage 4 ulcer. The Administrator, Director of Nursing and the Corporate Nurse were notified of the immediate jeopardy on 4/4/14. The Immediate Jeopardy was removed on 4/7/14 but the noncompliance remained at the lower scope and severity with no actual harm but potential for more than minimal harm that is not immediate jeopardy when the</p>	F000314	<p><b>F314</b></p> <ol style="list-style-type: none"> <li>Resident G pressure ulcer measurement was obtained on 3/27/14. The MD was contacted on 3/27/14 with new orders obtained and implemented. Resident G was admitted to the hospital on 3/28/14 and returned to the facility on 4/3/14. A head to toe skin assessment was completed on 4/3/14 and documented and treatment obtained.</li> <li>A full body skin check was completed for all guests beginning the evening of 4/3/14 and ending with completion on 4/4/14 to ensure accurate measurements and appropriate treatment interventions. All guests with pressure ulcers were reviewed by the RD on 4/4/14 with recommendations implemented as appropriate.</li> <li>Nursing staff was re-educated on Pressure Ulcer treatment beginning 4/14/14. /The LN training included: Skin Integrity standard, How to measure the wound, wound appearance and staging of wounds, and documentation of weekly skin assessments, when to notify the MD, Dressing</li> </ol>	04/29/2014

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	<p>facility developed and had implemented a systematic plan of correction but had not fully implemented the plan.</p> <p>Findings include:</p> <p>A. 1. The clinical record of Resident (G) was reviewed on 4/3/14 at 2:00 p.m. Diagnoses for the resident included, but were not limited to, rehabilitation for a fractured right humerus, dementia, hypertension and thyroid disorder. Resident (G) was admitted to the facility on 3/7/14.</p> <p>Resident (G) was observed briefly on 4/3/14 at 1:45 p.m. She was observed to have a healing left black eye and was found to have just returned to the facility still wearing a hospital gown. She was in a low bed with a low air-loss mattress. Bed alarms were in place.</p> <p>During an interview at that time, Resident (G) was unable to recall how she got the black eye. LPN #1 entered the room and indicated the resident had just returned from the hospital and was a little confused.</p> <p>During record review, an initial nursing admission assessment, dated 3/7/14 at 5:51 a.m., indicated Resident (G) was alert and oriented to self. She had no</p>		<p>changes, and handwashing related to treatment completion. CNA's were trained to notify the nurse of any skin condition noted while providing care and to use the Stop and Watch tool to notify the LN. DON/designee will monitor skin assessments including ensuring measurements are completed upon admission through Admission audits 5 x weekly. DON/designee will monitor weekly that skin assessment measurements are completed on a weekly basis. DSD/designee will perform random observations of dressing changes with 3 licensed nurses weekly x 2weeks, 2 licensed nurses weekly x 2 weeks, then 1 weekly thereafter.</p> <p>4. Results of audits will be forwarded to QA&amp;A for tracking and trending monthly for a minimum of 6 months with subsequent plans developed and implemented as needed.</p> <p>5. To be completed by 4/29/14.</p>				

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	<p>recent history of nutrition concerns, hydration concerns or weight loss, but had a diagnosis of malnutrition, failure to thrive or end-stage illness. She was dependent on staff for bathing, eating and toileting. She had occasional pain related to a right humerus fracture of her right arm. The full body skin inspection indicated a surgical incision with 18 staples to her right should and an upper forearm bruise. She was at risk for developing pressure ulcers. The initial skin interventions included a pressure reducing mattress, chair or wheelchair cushion and incontinence management.</p> <p>A change of condition Situation, Background, Assessment and Recommendation (SBAR) report, dated 3/16/14 at 10:30 p.m., indicated Resident (G) was observed to have an open area, stage 2 pressure ulcer on her coccyx. The area measured 3.0 cm x 1.0 cm x 0.3 cm. No tunneling or undermining was noted. The area was without drainage and non-granulating. The Nurse Practitioner (NP) was notified and a new order for DuoDerm treatments every 3 days and as needed was received.</p> <p>A pressure evaluation record, dated 3/16/14, indicated a stage 2 pressure area to the coccyx. The wound measured 3.0 cm x 1.0 cm x 0.3 cm.</p>						

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	<p>A SBAR report, dated 3/27/14 at 11:00 a.m., 11 days later, indicated a CNA reported during care she observed an open area on the coccyx. During the assessment, 3 wounds were observed. The first wound was noted at the top of the sacral. The wound measured 2.1 cm x 2.2 cm x 1.5 cm with undermining from 6-12 o'clock with 4.3 cm in depth. The wound had moderate amounts of yellow drainage and a foul odor was noted. The wound bed contained 90% slough and the edges were rolled under. The second wound was noted also at the top of the sacral, but slightly to the left side, under the first wound. The wound measured 1.0 cm x 1.0 cm with no drainage and 100% eschar to the wound bed. The area was not opened. The third wound was noted at the top/middle of the buttocks, just beside the second wound. The wound measured 1.3 cm x 1.0 cm x 0.1 cm. A small amount of clear drainage was noted and the wound bed was noted to have had epithelial tissue. The physician and family were notified of the wounds. A new order was received for Flagyl (antibiotic) 500 mg daily for 7 days, Rocephin (antibiotic) 1 gram intravenous, twice daily for 10 days, Norco (pain medication) 5/325, 1 every 4 hours as needed for moderate pain and two for severe pain. The wounds were</p>			

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	<p>cultured and a low air-loss mattress was ordered.</p> <p>The pressure evaluation records, dated 3/27/14, indicated the same measurements, color and drainage as above. The first wound was listed as a stage 3 pressure ulcer. The second wound was listed as unstageable. The third wound was listed as a stage 2 pressure ulcer.</p> <p>The physician order for treatment of the first wound was for it to be cleaned with normal saline and packed the undermining with a silver dressing. Apply TheraHoney to the open wound bed, apply Calazime to the peri-wound and cover with a thick foam dressing. The dressing was to be changed daily and as needed. The second wound was to be cleaned with normal saline, Calazime to the peri-wound and TheraHoney towards the wound bed and covered with a thick foam dressing. The dressing was to be changed daily. The third wound was to be cleaned with normal saline and Calazime to the entire area then covered with foam dressing. The dressing was to be changed daily.</p> <p>An SBAR, dated 3/28/14 at 1:30 p.m., indicated the physician was notified Resident (G) had been medicated with</p>						

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	<p>the strongest pain medication ordered and continued to scream and cry during and after treatment. The physician declined additional pain medication indicating he would review the pain medication later.</p> <p>Resident (G) was admitted to the hospital on 3/28/14 for a large decubitus ulcer on the coccyx full-thickness grade 4. She was given Vancomycin (antibiotic) and Zosyn (antibiotic) during her admission. The hospital records indicated her physical activity after discharge could gradually resume but, she was currently on bed rest related to a fractured right humerus and large coccyx decubitus ulcer. Physical therapy would be difficult secondary to dementia.</p> <p>Resident (G) was discharged from the hospital and returned to the facility on 4/3/14. The wound care instructions included packing the decubitus ulcer with Iodofoam gauze and then cover with a 4 x 4 dressing soaked in Dakin's (antiseptic solution). The wound was then to be covered with Tegaderm. An oral antibiotic was ordered for 10 days.</p> <p>A health care plan problem, dated 3/8/14, indicated the resident had the potential for impaired skin integrity related to impaired mobility, cognitive deficits and incontinence. The interventions for the</p>						

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	<p>problem included, but were not limited to, observe skin integrity during am/pm care, evaluate skin weekly and encourage repositioning.</p> <p>Another health care plan problem, dated 3/8/14, indicated Resident (G) had a self-care deficit related to a fractured right humerus. The problem indicated she was an extensive transfer, ambulation, locomotion, hygiene, bathing and dressing. She was dependent on staff for toilet use. The interventions included, but were not limited to, two person for transfer and bathing and one person assist for dressing, toilet use and personal hygiene.</p> <p>A current health care plan problem, dated 3/27/14, indicated an actual pressure ulcer. The interventions for the problem included, but were not limited to, pain medication prior to wound care, assess pressure ulcer weekly by licensed nurse and reposition every one hour in bed. No care plan was produced for the initial 3/16/14 pressure ulcer.</p> <p>The most recent Minimum Data Set (MDS) assessment indicated Resident (G) was severely cognitively impaired. Resident (G)'s active diagnoses included, but were not limited to, hypertension, other fracture, non-Alzheimer's dementia,</p>			

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	<p>anxiety and depression. Her current swallowing and nutritional status indicated no symptoms of a swallowing disorder. Resident (G) had no recent weight loss in the past 6 months. Her skin condition indicated no risk of developing a pressure ulcer and no history of an unhealed pressure ulcer. She had a current surgical wound and skin tear. Resident (G) received the following Activities of Daily Living (ADL) assistance; transfer-total dependence with two person physical assist, ambulation-did not occur, dressing, eating, toilet use and person hygiene-extensive assist with one person physical assist. Resident (G) was frequently incontinent of urine and continent of bowel.</p> <p>The pressure evaluation records, dated 4/3/14, indicated a stage 3 coccyx wound. The wound measured 4.6 cm x 2.2 cm x 1.0 depth. The wound bed contained 100% eschar, light serosanguineous drainage that was malodorous. The treatment stated "tx-hosp-Iodofoam, gauze, Dakin's solution. No tunneling or undermining was listed.</p> <p>During observation of wound care on 4/3/14 at 2:45 p.m., RN #2 and an unidentified CNA, rolled Resident (G) onto her left side for treatment. RN #2</p>			

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	<p>removed the old, undated, timed or initialed dressing and exposed a large open area with tendon and/or bone exposed. The most recent pressure evaluation dated 4/3/14, indicated a stage 3 pressure ulcer. The area was left open and the DoN was asked to come and observe the area.</p> <p>On 4/3/14 at 2:50 p.m., the DoN observed the pressure wound and indicated the wound was a stage 4. She proceeded to measure the wound. The wound measured 4.6 cm x 2.5 cm and the depth varied around the bone. The wound had undermining from 7-5 o'clock. The wound bed contained 75% slough and had heavy, serosanguineous drainage. The wound edges were rolled under. The resident continued to cry and complain of pain. The DoN asked RN #2 if the resident had been pre-medicated with pain medication, RN #2 stated "no". The treatment was then put on hold until pain medication had been given with some relief.</p> <p>On 4/3/14 at 3:45 p.m. RN #2 indicated Resident (G) was ready for her treatment. LPN #3 indicated Resident (G) had been given her oral pain relief medication. Resident (G) was rolled onto her left side by an unidentified CNA. RN #2 indicated for LPN #3 to remove the</p>			

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	<p>Iodofoam from the bottle and cut a strip. LPN #3 removed approximately 18 inches from the bottle, crumpled the dressing in her right hand then poured the Dakin's solution into her hand and over the dressing. RN #2 then took the soaked dressing and applied it directly into the wound. The wound was then covered with a dry 4 x 4 gauze and secured with Tegaderm. The dressing was not dated, timed or initialed by RN #2. RN #2 removed her donned gloves and washed in her hands in the bathroom for 7 seconds.</p> <p>On 4/5/14 at 9:45 a.m., Resident (G)'s chart was reviewed for physician orders. The discharge instructions indicated the decubitus ulcer should have been packed with Iodofoam dressing then covered with 4 x 4 gauze that had been soaked in Dakin's solution and covered with Tegaderm.</p> <p>On 4/5/14 at 10:45 a.m., the Corporate Nurse was provided the information related to the observed dressing change on 4/4/14.</p> <p>During an interview on 4/3/14 at 2:35 p.m., the Director of Nursing (DoN) indicated Resident (G) was very debilitated. She indicated when the pressure ulcer was noted on 3/27/14, the</p>				

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	<p>physician ordered for the resident to be sent to the hospital for an X-ray and a surgical consult.</p> <p>During an interview on 4/4/14 at 5:10 p.m., the Corporate Nurse indicated no pressure evaluation sheets were available after the 3/16/14 assessment during the time to the sheets dated 3/27/14. No measurement, depth of tunneling or assessment of the wound/skin area were documented for eleven days. She indicated they did not have staff initial, date or time the dressing change.</p> <p>B.1. The clinical record for Resident (I) was reviewed on 4/4/14 at 9:10 a.m. Diagnoses for the resident included, but were not limited to, anoxic brain injury, aspiration pneumonia, tracheostomy and mental retardation. Resident (I) was admitted to the facility on 3/11/14.</p> <p>During record review, a nursing admission assessment, dated 3/29/14 at 4:40 p.m., indicated Resident (I) returned from the hospital. He was listed in a comatose state with 3+ bilateral edema to upper and lower extremities. He had a urinary catheter in place. The full body inspection indicated 3 non-pressure areas that measured 2.5 cm x 1.0 cm, 4.0 x 2.5 cm and 4.0 cm x 4.5 cm. Resident (I) was also noted to have a stage 3 wound</p>						

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	<p>to his coccyx and sacrum and a undetermined wound to his ischium. No measurements were noted.</p> <p>Review of the pressure evaluation record, dated 4/2/14, indicated Resident (I) had a right clavicle, stage 2 wound that measured 1.0 cm x 1.0 cm. The wound was noted to have scant, serous drainage. Another wound report indicated a left clavicle, stage 2 wound that measured 1.5 cm x 1.5 cm. The wound had scant, serous drainage. Resident (I) was also noted to have a right lower buttock, stage 2 wound that measured 1.0 cm x 1.5 cm x 0.1 cm. The wound had scant, serous drainage. Another wound report indicated a sacral, stage 3 wound that measured 4.5 x 2.5 x 0.1 cm. The wound had scant, serous drainage. The wound bed contained 100% slough with the edges rolled under. Resident (I) was noted to have a left heel wound that was Unable to Determine (UTD). The wound measured 4.0 cm x 3.0 cm with no depth. The wound contained 100 % eschar. Another wound report indicated a left lateral thigh /buttocks wound. The wound was a stage 3 and measured 5.0 cm x 5.5 cm x 3.0 cm with light, purulent drainage. The wound bed contained 95% slough and 5% eschar. The edges were rolled under.</p>			

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	<p>A current health care plan problem, dated 4/2/14, indicated an actual pressure ulcer. The interventions for the problem included, but were not limited to, check dressing every shift, assess pressure ulcers weekly by licensed nurse and notify MD if the ulcers fail to heal every 2 weeks.</p> <p>The most recent Minimum Data Set (MDS) assessment, dated 3/14/14, indicated Resident (I) was severely cognitively impaired. His skin condition indicated he was at risk for developing pressure ulcers and had more than 1 unhealed pressure ulcer. The MDS indicated Resident (I) had 5 stage 1 pressure ulcers, 3 stage 3 pressure ulcers and 2 stage 3 pressure ulcers. Five of five pressure ulcers that were greater than a stage 2, indicated Resident (I) was admitted with. Resident (I) received the following Activities of Daily Living (ADL) assistance; transfer-did not occur, ambulation-did not occur, dressing-total dependent with 2 person physical assist, eating, toilet use and person hygiene-extensive assist with one person physical assist. Resident (I) was always incontinent of bowel and had a urinary catheter.</p> <p>Resident (I) was initially admitted to the facility on 3/11/14. He was discharged to</p>			

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	<p>the hospital on 3/15/14 and returned on 3/21/14. He was again admitted to the hospital on 3/25/14 and returned on 3/29/14.</p> <p>During observation of wound care on 4/4/14 at 9:00 a.m., RN #2 and LPN #4 attempted to roll Resident (I) on his right side for treatment. They were unable to position him completely and an unidentified CNA came to assist. Resident (I) was rolled onto his right side. A soiled dressing was removed from his left sacral wound. The dressing did not have any initials, date or time of change. The wound measured 4.9 cm x 5.2 cm x 1.4 cm depth. The large area to the left was open and approximately the size of a golf ball. RN #2 applied Calazime to the outer entire area. She then applied TheraHoney to the outer edges of the wound. The wound was covered with Optifoam and secured with Tegaderm. Following the dressing change, RN #2 washed her hands for less than 10 seconds.</p> <p>During observation of wound care on 4/4/14 10:20 a.m., RN # washed her hands for 10 seconds then donned gloves. She removed Resident (I)'s inflated boot from his left foot. No dressing was covering the wound. RN #2 measured the wound on the left heel. The wound</p>						

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	<p>measured 2.8 cm x 3.6 cm with no depth. She applied Betadine then heel prep. Optifoam was placed over the wound and the foam was then covered with Kerlix. RN #2 washed her hands after completing the treatment for 8 seconds, then washed them again at 10:35 a.m. for 8 seconds.</p> <p>Resident (I) was fatigued and RN #2 decided to wait for the next dressing change.</p> <p>During observation of wound care on 4/4/14 at 2:10 p.m., RN #2 and a unidentified CNA rolled the resident to his left side. An area to the right lower buttocks did not require treatment per RN #2. The sacral wound measured 2.9 cm x 4.3 cm with no depth. The wound was cleaned with wound cleaner and Calazime was applied to the outer edges. Medihoney was applied to the wound bed and the area was covered with foam. No dressing was noted to either the left or right clavicle. RN #2 indicated she would check on it later because she could not find any wounds.</p> <p>During review of the Treatment Administration Record (TAR)'s report, the March 2014 record indicated a wound #8 was on his left lower buttocks. The treatment was "to apply calmo to area</p>				

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	<p>every shift and as needed when soiled."</p> <p>Resident (I) received no treatment on 3/22, 3/23 and 3/30. The April TAR's indicated he did not receive treatment on 4/2 and 4/3.</p> <p>The March TAR's indicated a wound #7 on his lower back/middle. The treatment was "to clean with wound cleanser, apply Duodenum then cover with thick foam dressing. Change every 3 days."</p> <p>Resident (I) did not receive treatment on 3/30. The wound was not listed on the April TAR's.</p> <p>The March TAR's indicated a wound #6 to his left lower back/sacral. The treatment was "to clean with wound cleanser, apply DuoDerm, cover with thick foam dressing. Change every 3 days." Resident (I) was out to the hospital and last received a treatment March 24, 2014. The April TAR's indicated a similar sacral wound to be cleaned with normal saline, apply calmo to peri-wound edges, apply TheraHoney to wound bed only, cover with thick foam dressing and change daily and as needed. That order was not received until 4/2/14. The treatment was done on 4/2 and 4/3/14.</p> <p>The March TAR's indicated a wound #5 to his left top buttocks/sacral. The</p>			

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	<p>treatment was to "clean with wound cleaner, apply DuoDerm, cover with thick dressing and change daily and as needed." Resident (I) did not receive those treatments from 3/15-3/21 while he was in the hospital. He also did not receive those treatments from 3/25-3/29 while he was in the hospital. The treatments were not given 3/22-3/24/14 following his return or 3/30-3/31 following his return to the facility. The order was dated 3/15/14 and the only treatment given was on 3/24/14. The TAR's for April only indicated a sacral wound.</p> <p>The March TAR's indicated a wound #4 to his left top buttocks/sacral. The treatment was to "clean with wound cleanser, apply DuoDerm, cover with thick foam dressing and change every 3 days." The last documented treatment was 3/24/14. The order was dated 3/15/14 and the only treatment given was on 3/24/14. The TAR's for April only indicated a sacral wound.</p> <p>The March TAR's indicated a wound #3 to his top middle of buttocks/sacral. The order and treatment dates listed were the same as wound #4. The TAR's for April only indicated a sacral wound.</p> <p>The March TAR's indicated a wound #2.</p>						

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	<p>No location was noted. The wound was to be cleaned with normal saline, calmo applied to the peri-wound only, TheraHoney applied to the wound bed only and covered with a thick foam dressing. The treatment was ordered daily. The treatment was not done 3/22, 3/23 or 3/30/14.</p> <p>The April TAR's indicated wound #2. The same order was listed. Resident (I) did not receive treatment on 4/2 or 4/3/14.</p> <p>The March TAR's indicated a wound #1 to his left hip/buttock. The treatment was to "clean with normal saline, apply calmo to peri-wound, apply TheraHoney to wound bed and cover with thick foam dressing." The treatment was ordered daily. The treatment was not done on 3/22, 3/23 or 3/30/14.</p> <p>Resident (I) also had a left and right clavicle wound. The treatment was to "clean with wound cleanser, place DuoDerm under trach collar." The treatment was ordered every 3 days. Resident (I) readmitted on 3/29/14 and the treatment was not done until 4/2/14.</p> <p>The March TAR's indicated treatment to the left heel. The treatment included skin prep, Betadine and to cover with a thick</p>			

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	<p>foam dressing and wrap with Kerlix. The treatment was ordered daily. The treatment was not done on 3/22, 3/23 or 3/31.</p> <p>The March TAR's indicated skin prep daily to bilateral feet. The treatment was not done on 3/22, 3/23 or 3/30/14.</p> <p>2. Review of a current facility policy for "Skin Integrity Standard", provided by the Corporate Nurse on 4/5/14 at 10:45 a.m., included, but was not limited to the following:</p> <p>"Practice: Residents identified to be at risk for skin breakdown (pressure ulcers) ...</p> <p>Procedure: All new admissions will have a skin risk assessment (Braden or Norton Scale) and an initial head to toe skin assessment by Licensed Nurse and/or designated wound nurse as soon as possible within the first two hours of admission but no later than 24 hours of resident admission.</p> <p>New admission residents will have a weekly for three weeks... Care plan implementation of a preventative program... Communication by CNA to licensed nurse...</p>						

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	<p>Weekly "head to toe" assessment of all residents...</p> <p>If skin integrity issues are identified post-admission to the facility the following documented information is required:</p> <ol style="list-style-type: none"> <li>1. Wound Specifics: <ol style="list-style-type: none"> <li>a. Location of wound...</li> <li>b. Size of the wound...</li> <li>h. Stage of the wound...</li> </ol> </li> <li>5. Incident Report completed for in house acquired State III and/or IV.</li> </ol> <p>*DON/Designee completes weekly random skin assessments.</p> <p>*Verification of Pressure Logs will be completed by DON/Designee...</p> <p>*The DNS/DON/Designee monitors and trends acquired pressure ulcers to determine potential patterns related to occurrence. This trend information is reported at the QA&amp;A Meeting."</p> <p>Review of a current facility policy for "Hand Washing", provided by the Corporate Nurse on 4/5/14 at 10:45 a.m., included, but was not limited to, the following:</p> <p>"...Purpose Medical asepsis to control infection.</p> <p>General Instructions</p>				

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	<p>Wash hands before and after resident contact. Wash hands when soiled.</p> <p>Procedure</p> <p>7. Rub hands briskly using sufficient lather and friction for ten to fifteen seconds, pay special attention to area between fingers."</p> <p>3. The Immediate Jeopardy that began on 3/22/14 was removed on 4/7/14 when the facility implemented a systematic plan that included the following actions:</p> <p>1.) Total head to toe skin assessments on all 45 residents. The assessments were completed on 4/5/14.</p> <p>2). Training of licensed nurses and CNA's related to, skin integrity standard, measuring wounds, wound appearance, staging of wounds and documentation of weekly skin assessments. The in-service included hand washing and dressing changes. CNA's were also trained to notify the nurse of any skin condition noted while providing care. The in-servicing included 24 staff members.</p> <p>3). DoN/designee will monitor skin assessments and measurements be completed on admission through</p>				

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F000333 SS=J	<p>admission audits 5 x weekly. Monitor that skin measurements are completed weekly. Perform random observation of dressing change weekly x 2 weeks with 3 nurses, 2 nurses weekly x 2 weeks then 1 weekly thereafter.</p> <p>4). Licensed staff to date and initial dressing changes and the DoN/designee will monitor for compliance until all staff have been trained. The in-service was completed on 4/7/14.</p> <p>The noncompliance remained at a level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because all the licensed nursing staff had not yet demonstrated the ability to follow physician orders for a dressing change and handwashing skills.</p> <p>This federal tag relates to Complaint IN00146653.</p> <p>3.1-40(a)(1)(2)</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.</p>			

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	<p>Based on interview and record review, the facility failed to administer intravenous antibiotics as ordered by the physician, resulting in a significant medication error for 1 of 8 residents reviewed for medication administration. (Resident F)</p> <p>This deficient practice resulted in Immediate Jeopardy. This Immediate Jeopardy began on 2/14/14 when facility staff failed to identify and order intravenous antibiotic ordered by the physician. The Administrator, Director of Nursing and Corporate Nurse were notified of the immediate jeopardy on 4/4/14. The Immediate Jeopardy was removed on 4/7/14 but the noncompliance remained at the lower scope and severity with no actual harm but potential for more than minimal harm that is not immediate jeopardy when the facility developed and had implemented a systematic plan of correction but had not completed it.</p> <p>Findings include:</p> <p>The clinical record for Resident (F) was reviewed on 4/3/14 at 11:40 a.m. Diagnoses for the resident included, but were not limited to, multiple cerebral lesions, pneumonia, convulsions, malaise and chronic airway obstruction.</p>	F000333	<p><b>F333</b></p> <ol style="list-style-type: none"> <li>The MD for F was contacted regarding the missed antibiotic doses as well as the Infectious disease physician on 3/17/14. New orders were received and implemented. F antibiotic was initiated on 3/18/14.</li> <li>The facility reviewed all guests with orders for antibiotics to ensure timely initiation and addressed any issues identified as appropriate.</li> <li>Training of Licensed staff began on the evening of 4/4/14 on implementing antibiotic orders timely and ensuring antibiotics have been delivered from the pharmacy. DON/designee will monitor compliance through Admission audits which will be completed within 72 hours of admission.</li> <li>Results of audits will be forwarded to QA&amp;A for tracking and trending monthly for a minimum of 6 months with subsequent plans developed and implemented as needed.</li> <li>To be completed by 4/29/14.</li> </ol>	04/29/2014			

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	<p>The physician order, dated 1/27/14, indicated a discharge order from an infectious disease consult for the following medications to be started on admission to the facility on 2/14/14: "Flagyl (antibiotic) 500 mg by mouth every 6 hours, Rocephin (antibiotic) 2 gram intravenously every 12 hours and Vancomycin (antibiotic) per pharmacy for brain abscess." The order indicated to keep the trough range between 19-20 mcg/ml. The antibiotic stop date was to be determined.</p> <p>A pharmacist dosing recommendations fax sheet, dated 3/17/14 at 9:35 a.m., requested a physician's signature. The physician signature line stated "per original order signed by...". The dosing recommendation was 1000mg Vancomycin every 8 hours. The pharmacist signed the recommendation on 3/16/14.</p> <p>Review of the March Medication Administration Record (MAR), Resident (F) received his first dose of Vancomycin on 3/18/14. The original order stated to start medication 2/14/14.</p> <p>A current health care plan problem/need, dated 2/15/14, indicated a potential for infection related to a Peripherally</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>Inserted Center Catheter (PICC) line. The interventions for plan included, but were not limited to, administer IV fluid/medication as ordered and measure external catheter length on admission, with each dressing change and as needed.</p> <p>The most recent Minimum Data Set (MDS) assessment indicated Resident (F) was cognitively intact. Resident (F) was independent with all Activities of Daily Living (ADL). Resident (F)'s current diagnoses included, but were not limited to, cancer (with or without metastasis), pneumonia and asthma.</p> <p>During an interview on 4/3/14 at 11:40 a.m., the Director of Nursing (DoN) stated Resident (F) was out of the building today for brain surgery.</p> <p>During an interview on 4/3/14 at 12:00 p.m. with the DoN, a copy of the physician order for the 3/17/14 Vancomycin was requested. She indicated it was on the original order from admission and the pharmacy requested a signature so she wrote "per original order". She then stated the resident did not get his antibiotic until after she realized it had not been ordered. She stated both the physician and consulting infectious disease specialist were notified. She indicated the</p>			

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F000441	<p>483.65</p> <p>infectious disease specialist was not happy the resident failed to receive the doses of antibiotic.</p> <p>As of 4/5/14, Resident (F) had not returned to the facility following surgery.</p> <p>The Immediate Jeopardy that began on 2/14/14 was removed on 4/7/14 when the facility implemented a systematic plan that included the following actions:</p> <p>1). The facility reviewed all residents admitted on/and or after 2/1/14 for the accuracy of the medication and/or antibiotic orders. The assessment was completed on 4/5/14.</p> <p>2). The in-service included ensuring medication and/or antibiotics are delivered timely and completely. The DoN/designee will monitor compliance through Admission audits which will be completed within 72 hours of admission. The in-servicing included 24 staff members.</p> <p>This federal tag relates to Complaint IN00146653.</p> <p>3.1-25(b)(9)</p>						

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SS=D	<p><b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b></p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and record review, the facility failed to ensure</p>	F000441	<p><b>F441</b></p> <p>1. Facility is unable to correct</p>	04/29/2014	

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	<p>infection control practices were followed related to hand washing for 2 of 4 residents observed during resident care. (Resident G, I).</p> <p>Findings include:</p> <p>1). The clinical record of Resident (G) was reviewed on 4/3/14 at 2:00 p.m. Diagnoses for the resident included, but were not limited to, rehabilitation for a fractured right humerus, dementia, hypertension and thyroid disorder.</p> <p>During observation of wound care on 4/3/14 at 2:45 p.m., RN #2 and an unidentified CNA, rolled Resident (G) onto her left side for treatment. RN #2 removed the old, undated, timed or initialed dressing and exposed a large open area with tendon and/or bone exposed. The most recent pressure evaluation dated 4/3/14, indicated a stage 3 pressure ulcer. The area was left open and the DoN was asked to come and observe the area.</p> <p>On 4/3/14 at 2:50 p.m., the DoN observed the pressure wound and indicated the wound was a stage 4. She proceeded to measure the wound. The wound measured 4.6 cm x 2.5 cm and the depth varied around the bone. The wound had undermining from 7-5</p>		<p>alleged deficiency for Residents G &amp; I due to occurring in the past.</p> <p>2. The facility reviewed all residents with pressure ulcers on 4/4/14.</p> <p>3. Licensed staff to be in-serviced on policy and procedures for hand washing during dressing changes.</p> <p>4. DSD/designee will perform random observations of dressing changes with 3 licensed nurses weekly x 2 weeks, 2 licensed nurses weekly x 2 weeks, then 1 weekly thereafter. The audits will be reviewed and monitored through QA monthly.</p> <p>5. To be completed by 4/29/14.</p>				

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	<p>o'clock. The wound bed contained 75% slough and had heavy, serosanguineous drainage. The wound edged were rolled under. The resident continued to cry and complain of pain. The DoN asked RN #2 if the resident had been pre-medicated with pain medication, RN #2 stated "no". The treatment was then put on hold until pain medication had been given with some relief.</p> <p>On 4/3/14 at 3:45 p.m. RN #2 indicated Resident (G) was ready for her treatment. LPN #3 indicated Resident (G) had been given her oral pain relief medication. Resident (G) was rolled onto her left side by an unidentified CNA. RN #2 indicated for LPN #3 to remove the Iodofoam from the bottle and cut a strip. LPN #3 removed approximately 18' from the bottle, crumpled the dressing in her right hand then poured the Dakin's solution into her hand and over the dressing. RN #2 then took to soaked dressing and applied directly into the wound. The wound was then covered with a dry 4 x 4 gauze and secured with Tegaderm. The dressing was not dated, timed or initialed by RN #2. RN #2 removed her donned gloves and washed in her hands in the bathroom for 7 seconds.</p> <p>On 4/5/14 at 9:45 a.m., Resident (G)'s</p>						

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	<p>chart was reviewed for physician orders. The discharge instructions indicated the decubitus ulcer should have been packed with Iodofoam dressing then covered with 4 x 4 gauze that had been soaked in Dakin's solution and covered with Tegaderm.</p> <p>On 4/5/14 at 10:45 a.m., the Corporate Nurse was provided the information related to the observed dressing change and infection control concerns on 4/4/14.</p> <p>2). The clinical record for Resident (I) was reviewed on 4/4/14 at 9:10 a.m. Diagnoses for the resident included, but were not limited to, anoxic brain injury, aspiration pneumonia, tracheostomy and mental retardation. Resident (I) was admitted to the facility on 3/11/14.</p> <p>During record review, a nursing admission assessment dated 3/29/14 at 4:40 p.m., indicated Resident (I) returned from the hospital. He was listed in a comatose state with 3+ bilateral edema to upper and lower extremities. He had a urinary catheter in place. The full body inspection indicated 3 non-pressure areas that measured 2.5 cm x 1.0 cm, 4.0 x 2.5 cm and 4.0 cm x 4.5 cm. Resident (I) was also noted to have a stage 3 wound to his coccyx and sacrum and a undetermined wound to his ischium. No</p>						

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	<p>measurements were noted.</p> <p>Resident (I) was initially admitted to the facility on 3/11/14. He was discharged to the hospital on 3/15/14 and returned on 3/21/14. He was again admitted to the hospital on 3/25/14 and returned on 3/29/14.</p> <p>During observation of wound care on 4/4/14 at 9:00 a.m., RN #2 and LPN #4 attempted to roll Resident (I) on his right side for treatment. They were unable to roll completely and an unidentified CNA came to assist. Resident (I) was rolled onto his right side. A soiled dressing was removed from his left sacral wound. The dressing did not have any initials, date or time of change. The wound measured 4.9 cm x 5.2 cm x 1.4 cm depth. The large area to the left was open and approximately the size of a golf ball. RN #2 applied Calazime to the outer entire area. She then applied TheraHoney to the outer edges of the wound. The wound was covered with Optifoam and secured with Tegaderm. Following the dressing change, RN #2 washed her hands for less than 10 seconds.</p> <p>During observation of wound care on 4/4/14 10:20 a.m., RN # washed her hands for 10 seconds then donned gloves. She removed Resident (I)'s inflated boot</p>						

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	<p>from his left foot. No dressing was covering the wound. RN #2 measured the wound on the left heel. The wound measured 2.8 cm x 3.6 cm with no depth. She applied Betadine then heel prep. Optifoam was placed over the wound and the foam was then covered with Kerlix. RN #2 washed her hands after treatment for 8 seconds then washed them again at 10:35 a.m. for 8 seconds.</p> <p>3. Review of a current facility policy for "Hand Washing", provided by the Corporate Nurse on 4/5/14 at 10:45 a.m., included, but was not limited to, the following:</p> <p>"...Purpose Medical asepsis to control infection.</p> <p>General Instructions Wash hands before and after resident contact. Wash hands when soiled.</p> <p>Procedure 7. Rub hands briskly using sufficient lather and friction for ten to fifteen seconds, pay special attention to area between fingers."</p> <p>This Federal tag relates to Complaint IN00146653.</p>						

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F009999	<p>3.1-18(I)</p> <p style="text-align: center;">State Findings</p> <p>3.1-18(a) The facility must establish and maintain an infection control program designated to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infections.</p> <p>(e) In addition, a tuberculin skin test shall be completed within 3 months (3) prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with a date given, date read, and by whom administered and read.</p> <p>This state rule was not met as evidence by:</p> <p>Based on interview and record review, the facility failed to ensure residents received a tuberculin test on admission or annually for 1 of 4 sampled residents. (Resident E)</p> <p>Findings include:</p>	F009999	<p><b>F9999-State Tag</b></p> <ol style="list-style-type: none"> <li>1. Facility to administer and update tuberculin tests for Resident E.</li> <li>2. Facility to audit all guests for admission and annual tuberculin tests.</li> <li>3. Facility to audit all guests for admission and annual tuberculin tests. Nursing staff to be in-serviced regarding policy and procedures for administering tuberculin tests on admission and annually thereafter.</li> <li>4. Medical Records or designee to implement a monthly audit tool for upcoming annual tuberculin tests. Medical Records or designee to audit all new admissions for tuberculin tests 5x/week for three weeks then 2x/week for three weeks then weekly thereafter. The audits will be reviewed and monitored through QA monthly.</li> <li>5. To be completed by 4/29/14.</li> </ol>	04/29/2014			

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	<p>The clinical record for Resident (E) was reviewed on 4/2/14 at 1:45 p.m. Diagnoses for the resident included, but were not limited to, cystic malignant neoplasm of exocrine pancreas, chronic cor pulmonale, diabetes mellitus, hypertension, cirrhosis of liver and morbid obesity.</p> <p>Resident (E) was admitted to the facility on 3/31/14. During review of the current immunization record, Resident (E) did not receive a 1st step tuberculin test or risk assessment. Resident (E) was given the 1st step on 4/2/14 and the test was read on 4/4/14.</p> <p>Review of a current facility policy, titled "Infection Prevention Manual for Long Term Care", which was provided by the Corporate Nurse on 4/7/14 at 9:15 a.m., indicated the following;</p> <p>"C. ADMISSIONS</p> <ol style="list-style-type: none"> <li>1. All residents will be screened on admission for infection with tubercle bacilli on admission...</li> <li>2. Screening for infection will consist of a TST (Mantoux) using 5 units of PPD...</li> </ol> <p>No additional information was provided during the exit conference.</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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