

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155799	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/24/2016
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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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F 0000 Bldg. 00	<p>This visit was for the investigation of Complaint IN00202838.</p> <p>Complaint IN00202838 - Substantiated. Federal/State deficiencies related to allegations are cited at F224, F281 and F333.</p> <p>Survey dates: June 23 and 24, 2016.</p> <p>Facility number: 012809 Provider number: 155799 AIM number: 201136580</p> <p>Census bed type: SNF: 26 SNF/NF: 17 Total: 43</p> <p>Census Payor type: Medicare: 13 Medicaid: 17 Other: 13 Total: 43</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>QR completed by 11474 on June 29,</p>	F 0000	<p>This plan of correction is prepared and executed because the provision of state and federal law require it and not because Marion Rehabilitation and Assisted Living Center agrees with the allegations made in the cited deficiencies. The facility maintains that the deficiencies do not jeopardize the health and safety of guests, nor are they of such character so as to limit our capability to render adequate care. Please consider this plan of correction as our credible statement of compliance. We respectfully request paper compliance.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0224 SS=D Bldg. 00	<p>2016.</p> <p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROP RIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to ensure medications were not misappropriated for any resident other than the resident for whom the medication was prescribed. This deficiency affected 1 of the 4 residents reviewed for misappropriation of medications.</p> <p>Findings include:</p> <p>During a review, on 6/23/2016 at 3:52 p.m., of recent facility self reportables, an investigative report involving missing medication for Resident B was reviewed. The investigative report indicated that on 6/13/2016 LPN #9 wrote an order for Skelaxin (muscle relaxant) 800 mg three times a day. LPN #9 gave a dose of</p>	F 0224	<p>F2241) Resident B no longer resides in the facility, but upon notification of incident, this resident was assessed by the DON on 6-13-16 and the pharmacy was contacted to have the medication replaced at the facility's cost.2) 27 residents had the potential to be affected by the alleged deficient practice. An audit was conducted comparing physician orders to current medication supply to ensure that all medications are available.3) The DON/designee initiated re-education with the licensed nurses on misappropriation of medications on 6-14-16.4) Monitoring: A review of medication availability will be conducted by the DON/licensed designee 5 times per week for 4 weeks, the 3 times per week for 4</p>	07/24/2016	

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	<p>Skelaxin on 6/13/2016 to Resident B. LPN #9 did not communicate with the physician nor the nurse practitioner before writing the order and giving the medication. The Investigative Report indicated the facility did an audit to determine what other residents were receiving Skelaxin at the same time. The Audit indicated no other residents had an active order for Skelaxin, however one resident had a discontinued order for Skelaxin. Pharmacy was contacted by the facility and was informed 45 Skelaxin 800 mg tablet were delivered to the facility on 5/29/2016 but the order was discontinued on 6/1/2016. The facility determined, based on the order date, there should have been 34 tablets left. During the audit it was determined there were only 3 Skelaxin 800 mg tablets left. Pharmacy denied receiving the medications back for credit. Skelaxin was also not available in the EDK (emergency drug kit). The facility was unable to locate the missing 30 tablets.</p> <p>During an interview on 6/23/2016 at 3:40 p.m., the Administrator indicated LPN #9 had given medication to Resident B without an order from the physician or the NP (nurse practitioner). "She wrote a nursing note indicating she gave Skelaxin after she wrote an order for it at approximately 2:39 a.m. She didn't talk</p>		<p>weeks, then weekly for 4 months to ensure that all medications are available. Negative findings will be corrected immediately and reviewed monthly in QAA meetings for 6 months.</p>				

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	<p>to the NP until 6:00 a.m. and told her she had written the order and gave the medication. She stated the medication had been discontinued from another resident."</p> <p>During an interview on 6/23/2016 at 3:53 p.m., the DON (Director of Nursing) indicated the NP contacted her and informed her a nurse had written an order and given medication without speaking to the NP or the physician. "On 6/13/16 she wrote the order to start the medication on 6/14/16 and gave the resident a dose at that time. On 6/14 she (Resident B) got the second dose and started having some confusion. The medication was discontinued after the second dose. We reached out to the NP on 6/14/16 to get the medication discontinued." The DON indicated Resident B was assessed by the physician, labs were ordered, IV fluids were administered and Resident B discharged to home on 6/17/2016. "She (Resident B) started clearing up and got better. She discharged to home." The DON indicated nursing staff should never have written an order for medications without consulting with the physician first. The DON indicated the nurse should not give a resident medication if it was not prescribed to them by a physician. "We do not give a resident someone else's medication." The DON</p>			

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	<p>indicated LPN #9 was immediately suspended pending investigation.</p> <p>During an interview on 6/24/2016 at 7:23 a.m., LPN #2 indicated nurses must obtain an order from the physician or the NP before administering any medication or treatment. LPN #2 indicated nurses should never borrow medication from one resident to give to another resident.</p> <p>During an interview on 6/24/2016 at 7:36 a.m., RN #3 indicated the nurse must communicate with the physician any medical concerns and follow the physician orders. RN #3 indicated using a resident's medication for another resident was not allowed. "If you run out of a medication before it is refilled you can usually get it from the EDK (emergency drug kit). You shouldn't use medications from someone else."</p> <p>This federal tag relates to Complaint IN00202838.</p> <p>3.1-28(a)</p>			

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F 0281 SS=D Bldg. 00	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. Based on record review and interview, the facility failed to ensure residents were provided patient care in accordance to acceptable professional standards for 1 of 4 residents who were reviewed for medication order transcription. (Resident B)</p> <p>Findings include:</p> <p>The clinical record of Resident B was reviewed on 6/23/2016 at 7:44 a.m. Diagnoses included, but were not limited to, status post joint replacement, hypertension, diabetes type 2, restless leg syndrome and depressive episodes.</p> <p>Review of a nursing note, dated 6/13/2016 at 3:52 a.m., indicated an order was written for Resident B to receive</p>	F 0281	F2811) Resident B no longer resides in the facility, but upon notification of incident, this resident was assessed by the DON on 6-13-16 and the pharmacy was contacted to have the medication replaced at the facility's cost.2) 27 residents had the potential to be affected by the alleged deficient practice. Orders written by this nurse for the past 45 days will be reviewed to ensure that no other residents have been affected.3) The DON/designee initiated re-education on 6-14-16 for the licensed nurses on checking medications against the MAR to ensure that adequate supplies of medication are always available.4) Monitoring will be accomplished by utilizing our complaint/grievance procedure, ABAQIS interviews, and quality rounds which will be reviewed 5	07/24/2016	

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	<p>Skelaxin (muscle relaxant) 800 mg three times a day for muscle spasms.</p> <p>Review of a nursing note, dated 6/13/2016 and the MAR (medication administration record) for June 2016, indicated Resident B received one dose of Skelaxin on 6/13/2016 and another dose on 6/14/2016.</p> <p>Review of a nursing note, dated 6/14/2016 at 2:07 p.m., indicated the order for Skelaxin was discontinued by the NP (nurse practitioner).</p> <p>During an interview on 6/23/2016 at 3:40 p.m., the Administrator indicated a nurse had given medication to Resident B without an order from the physician or the NP. "She wrote a nursing note indicating she gave Skelaxin after she wrote an order for it at approximately 3:00 a.m.. She didn't talk to the NP until 6:00 a.m. and told her she had written the order and gave the medication. She stated the medication had been discontinued from another resident."</p> <p>During an interview on 6/23/2016 at 3:53 p.m., the DON (Director of Nursing) indicated the NP contacted her and informed her a nurse had written an order and given medication without speaking to the NP or the physician. "On 6/13 she</p>		<p>days per week in morning meeting ongoing. Results will be reviewed in monthly QAA meetings for 6 months.</p>	

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	<p>wrote the order to start the medication on 6/14 and gave the a dose at that time. On 6/14 she (Resident B) got the second dose and started having some confusion. The medication was discontinued after the second dose. We reached out to the NP on 6/14 to get the medication discontinued." The DON indicated Resident B was assessed by the physician, labs were ordered, IV fluids were administered and Resident B discharged to home on 6/17/2016. "She (Resident B) started clearing up and got better. She discharged to home." The DON indicated nursing staff should never have written an order for medications without consulting with the physician first. The DON indicated the nurse in question was immediately suspended pending investigation and was terminated.</p> <p>During an interview on 6/24/2016 at 7:23 a.m., LPN #2 indicated nurses must obtain an order from the physician or the NP before administering any medication or treatment. LPN #2 indicated nurses should never borrow medication from one resident to give to another resident.</p> <p>During an interview on 6/24/2016 at 7:36 a.m., RN #3 indicated the nurse must communicate with the physician medical concerns and follow the physician orders.</p>				

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F 0333 SS=G Bldg. 00	<p>RN #3 indicated using another resident's medication for another resident is not allowed. "If you run out of a medication before it is refilled you can usually get it from the EDK (emergency drug kit). You shouldn't use medications from someone else."</p> <p>This federal tag relates to Complaint IN00202838.</p> <p>3.1-35(g)(1)</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> <p>Based on record review and interview, the facility failed to ensure 1 resident in a sample of 4 was free from a significant medication error resulting in the resident experiencing a change in mental status which required IV fluids and lab tests being done. (Resident B)</p> <p>Findings include:</p> <p>The clinical record of Resident B was reviewed on 6/23/2016 at 7:44 a.m. Diagnoses included, but were not limited to, status post joint replacement, hypertension, diabetes type 2, restless leg syndrome and depressive episodes.</p>	F 0333	<p>F3331) Resident B no longer resides in the facility, but upon notification of the incident, this resident was assessed by the DON on 6-13-16 and the pharmacy was contacted to have the medication replaced at the facility's cost.2) 27 residents had the potential to be affected by the alleged deficient practice. Orders written by this nurse for the past 45 days will be reviewed to ensure that no other residents have been affected.3) Re-education for the licensed nurses regarding significant medication errors was initiated on 6-14-16 by the DON/designee.4)Monitoring: Medication observations will be conducted by the DON/licensed</p>	07/24/2016			

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	<p>Review of a nursing note, dated 6/13/2016 at 3:52 a.m., indicated Resident B was started on Skelaxin (muscle relaxant) 800 mg three times a day for muscle spasms.</p> <p>Review of a nursing note, dated 6/13/2016 and the MAR (medication administration record) for June 2016, indicated Resident B received one dose of Skelaxin on 6/13 and another dose on 6/14/2016.</p> <p>Review of a nursing note, dated 6/14/2016 at 2:07 p.m., indicated the order for Skelaxin was discontinued by the NP (nurse practitioner).</p> <p>Review of the nursing note, dated 6/15/2016 at 3:20 a.m., indicated the following: "guest [sic] continues to show signs of confusion. Guest is oriented to place and time. Guest is having episodes of fright and asking where everyone is and thinks she is by herself. This nurse continues to remind guest that she is in a medical facility where there is staff 24 hours. guest [sic] states she is hearing daughter when daughter is not present. she [sic] is also seeing moving ceiling tiles, and having visuals of daughter in the walls. daughter [sic] staying in room with guest for the night. daughter [sic]</p>		<p>designee 3 times per week for 8 weeks, the weekly for 4 months. We will utilize our complaint/grievance procedure, ABAQIS interviews, and quality rounds which will be reviewed 5 days per week in morning meeting ongoing. Results will be reviewed in monthly QAA meetings for 6 months.</p>	

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	<p>stated that guest explained to daughter that she is afraid of this nurse poisoning her and out to get guest...."</p> <p>Review of a nursing note, dated 6/15/2016 at 7:08 a.m., indicated the following: "Spoke with (name of physician) regarding guest's continued increased confusion with visual and tactile hallucinations reported by staff and daughter. Order for CBC, Renal Panel and Doppler to right knee. (Name of surgeon) has been in contact with (name of physician) regarding guest. (name of physician) to come in to assess guest...Daughter at bedside and discussed medication review; new medication Skelaxin was discontinued 6/14 and guest started on Tramadol yesterday for pain control as opposed to hydrocodone. Daughter indicated that confusion was better today than last night. Guest in bed resting quietly with no complaints at this time."</p> <p>Review of a nursing note, dated 6/15/2016 at 7:59 p.m., indicated Resident B was seen by the physician due to recent episodes of confusion. The physician ordered labs, a peripheral IV placement and normal saline to be given at 75 ml per hour intravenously over 48 hours.</p>						

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	<p>During an interview on 6/23/2016 at 3:40 p.m., the Administrator indicated a nurse had given medication to Resident B without an order from the physician or the NP. "She wrote a nursing note indicating she gave Skelaxin after she wrote an order for it at approximately 3:00 a.m. She didn't talk to the NP until 6:00 a.m. and told her she had written the order and gave the medication. She stated the medication had been discontinued from another resident."</p> <p>During an interview on 6/23/2016 at 3:53 p.m., the DON (Director of Nursing) indicated the NP contacted her and informed her a nurse had written an order and given medication without speaking to the NP or the physician. "On 6/13 she wrote the order to start the medication on 6/14 and gave the resident a dose at that time. On 6/14 she (Resident B) got the second dose and started having some confusion. The medication was discontinued after the second dose. We reached out to the NP on 6/14 to get the medication discontinued." The DON indicated Resident B was assessed by the physician, labs were ordered, IV fluids were administered and Resident B discharged to home on 6/17/2016. "She (Resident B) started clearing up and got better. She discharged to home." The DON indicated nursing staff should never</p>			

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	<p>write an order for medications without consulting with the physician first. The DON indicated the nurse in question was immediately suspended pending investigation.</p> <p>During an interview on 6/24/2016 at 7:23 a.m., LPN #2 indicated nurses must obtain an order from the physician or the NP before administering any medication or treatment. LPN #2 indicated nurses should never borrow medication from one resident to give to another resident.</p> <p>During an interview on 6/24/2016 at 7:36 a.m., RN #3 indicated the nurse must communicate with the physician any medical concerns and follow the physician orders. RN #3 indicated using a resident's medication for another resident was not allowed. "If you run out of a medication before it is refilled you can usually get it from the EDK (emergency drug kit). You shouldn't use medications from someone else."</p> <p>This federal tag relates to Complaint IN00202838.</p> <p>3.1-25(b)(7) 3.1-25(b)(9) 3.1-48(c)(2)</p>			

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

PRINTED: 07/18/2016

FORM APPROVED

OMB NO. 0938-0391

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