STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		` '			(X3) DATE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		<u> </u>			COMPLETED 02/04/2016	
		155799	B. WI	NG		02/04/	2016	
	PROVIDER OR SUPPLIE	R I AND ASSISTED LIVING CENTER		614 WE	ADDRESS, CITY, STATE, ZIP CODE SST 14TH STREET N, IN 46953			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE	
F 0000								
Bldg. 00	State Licensure Residential State Survey dates: Ji February 1, 2, 3 Facility number Provider number AIM number: 20 Census bed type SNF/NF: 36 Residential: 31 Total: 67 Census payor ty Medicare: 13 Medicaid: 18 Other: 36 Total: 67 These deficienc cited in accorda 16.2-3.1.	: 012809 r: 155799 01136580	F 00	000	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 not jeopardize the health and safety of guests, nor are they such character so as to limit of capability to render adequate care. Please consider this plat correction as our credible statement of compliance. We respectfully request paper compliance.	eral e ne s do of ur		

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

TITLE

(X6) DATE

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

X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155799 B. WING 02/04/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 614 WEST 14TH STREET MARION REHABILITATION AND ASSISTED LIVING CENTER **MARION. IN 46953** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE  $\mathsf{TAG}$ F 0176 483.10(n) SS=D RESIDENT SELF-ADMINISTER DRUGS IF **DEEMED SAFE** Bldg. 00 An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. F 0176 F176 03/05/2016 Based on observation, interview and Corrective action for record review, the facility failed to residents affected by the determine the resident was safe for self alleged deficient practice: A administration by assessment prior to the medication resident administering their own self-administration medication (Resident #5). assessment for Resident 5 was completed on 2-1-16. Findings include: Identification of other During an observation of Resident #5's residents affected and room on 01/28/2016 8:22 a.m., a corrective action: All pharmacy bottle was observed sitting on residents who a table at bedside with a bottle of Systane self-administer their eye drop solution inside with an medications have been expiration date of 12/2015. The resident reviewed to ensure that a indicated her doctor had told her she medication could keep the medication at her bedside self-administration to use as needed. The directions on the assessment has been pharmacy bottle indicated to instill one completed. (No other drop into each eye once per day. residents in the facility Resident #5 indicated that she used the self-administer their eye drops several times during the day medications) every day as indicated by her doctor. Systemic changes to During an observation of Resident #5 on ensure that alleged

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) I			(X3) DATE	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>			COMPLETED	
		155799	B. WI	NG		02/04/	2016
			Ь-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	R			ST 14TH STREET		
MARION	REHABILITATION	AND ASSISTED LIVING CENTER			N, IN 46953		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		19 a.m., the pharmacy			deficient practice does no		
	bottle containing	g Systane eye drop			recur: Nursing staff will be	е	
	solution was obs	served sitting on the			educated on the		
	bedside table.				self-administration of		
					medication assessment		
	A review of the	medical record for			policy. Residents who wa	ant	
	resident #5 bega	n on 01/28/2016 9:58			to self-administer their		
	a.m. Diagnosis for the resident included, but were not limited to osteoporosis,				medications will be		
					assessed at admission a	nd	
	major depressive disorder, urinary				quarterly thereafter.		
	incontinence, and dry eye syndrome. The						
	most current Min				Monitoring of the correcti	ve	
		S), dated 12/30/2015,			action: The DON or		
	·	ident was cognitively			licensed designee will au	dit	
					new admissions and /or		
		s no care plan indicating			resident requests for self		
	Self-Administrat	tion for Resident #5.			administration of		
	ъ	·			medications 5 times per		
	_	iew with LPN #1 on			week for 4 weeks, then		
		28 a.m., she indicated			weekly for 8 weeks, then		
		e for the E Hall that day			monthly for 3 months to		
		as not a resident who			ensure proper and timely	,	
		d their medication on that			assessments. Results o		
	hallway.				audits will be reviewed		
					monthly at the QA&A		
	_	iew with Resident #5 on			meeting for 3 months or		
	02/01/2016 at 9:	40 a.m., she again			until a consistent pattern	of	
	indicated the doc	ctor told her she could			compliance is achieved.		
	have her prescrib	ped eye drops at her			p = 1 = 10 = 10 = 10 = 10 = 10 = 10 = 10		
	bedside. The pha	armacy bottle was					
	-	bedside table and labeled					
		nt's First and Last name					
	and indicated inside was Systane Balance						
		, instill one drop per eye					
	every two hours. The lid of the pharmacy						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPLETED			ETED	
		155799	B. W	ING		02/04/	2016
			_	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				ST 14TH STREET		
MARION	REHABILITATION	AND ASSISTED LIVING CENTER	₹		N, IN 46953		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, The state of the	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	bottle came off e	easily and there was a					
	bottle of Systane	Eye Drops in the					
	container. The d	lirections indicated to					
	instill one drop in	nto each eye once per					
	_	of Systane Ultra had a					
	manufacturer's e	_					
	12/2015.						
	12/2013.						
	During an interv	iew with I PN #1 on					
	During an interview with LPN #1 on						
	02/01/2016 at 1:18 p.m., she indicated						
		ent #5 had eye drops at					
		lid not know they were					
	expired. LPN #1	indicated there was now					
	a care plan for R	esident #5 in regards to					
	self-administration	on. LPN #1 then went					
	into Resident #5'	's room, checked the					
	medication bottle	e and indicated the					
	medication was S	Systane eye drop solution					
		drops were expired and					
	removed them fr						
	Temoved them if	on the room.					
	During an interv	iew with LPN #2 on					
	_	39 a.m., she indicated					
		sician order for Resident					
		2015, as only a bottle of					
		should be kept at the					
		should be kept at the					
	bedside.						
	During an interv	iew with the Director of					
	_	on 02/02/2016 at 9:46					
	J ~ /	ed that Artificial Tears					
	· ·	one in the same. The					
		hat Systane is the type of					
	artificial tears the	e resident was using.					

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AND PLAN OF CORRECTION   IDENTIFICATION NUMBER:   A. BUILDING   00   02/04/2016    NAME OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE   614 WEST 14TH STREET   MARION, IN 46953    (X4) ID   SUMMARY STATEMENT OF DEFICIENCIES   ID   TOWNSTAND ADDRESS   ID   (X5)	
NAME OF PROVIDER OR SUPPLIER  MARION REHABILITATION AND ASSISTED LIVING CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953	
MARION REHABILITATION AND ASSISTED LIVING CENTER  614 WEST 14TH STREET  MARION, IN 46953	
MARION REHABILITATION AND ASSISTED LIVING CENTER  614 WEST 14TH STREET  MARION, IN 46953	
MARION REHABILITATION AND ASSISTED LIVING CENTER MARION, IN 46953	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION)	J
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG DEFICIENCY)  DATE	•
The DON then indicated that there was	
not an assessment or care plan for	
medication self-administration for	
Resident #5 prior to 2/1/2016.	
During an interview with Resident #5 on	
02/04/2016 at 9:01 a.m., she indicated	
that she did not follow the directions on	
the bottle of her eye drops and that she	
was free to use them as she wanted. The	
pharmacy bottle containing the Systane	
eye drop solution was observed on the	
bedside table of Resident #5. The	
pharmacy bottle indicated [Resident first	
and last name] Systane Balance 0.6%	
with directions indicating to instill one	
drop per eye every two hours.	
drop per eye every two nours.	
A review of a physician order sheet for	
Resident #5, dated 11/13/2015, provided	
by the Business Office Manager (BOM)	
on 02/01/2016 at 12:59 p.m. indicated:	
"1. Artificial Tears as needed during	
daytime. (may keep at bedside)	
2. Systane gel @HS	
3. Restasis BID"	
A review of the Order Review Report for	
Resident #5 for the month of December,	
2015 was provided by the DON on	
2/3/2016 at 3:00 p.m. It indicated a	
physician order for "Systane Balance	
Solution instill one unit in both eyes	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			, ,		NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU B. W.	UILDING	00	COMPL	
		155799	D. W.	_		02/04/	2016
NAME OF F	PROVIDER OR SUPPLIER	L			DDRESS, CITY, STATE, ZIP CODE		
MADION	DEHARII ITATIONI	AND ASSISTED LIVING CENTER	5	1	ST 14TH STREET N, IN 46953		
			<u> </u>	<u> </u>	4, IIV <del>1</del> 0999	1	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
		as needed for dry eyes					
	1 -	EYE SYNDROME OF					
	UNSPECIFIED LACRIMAL GLAND" with an order date and start date of 11/13/2015.						
	A review of the Medication						
	Administration Record for Resident #5						
	for the month of December, 2015 began						
	on 02/01/2016 at 1:03 p.m. It indicated						
	"Systane Balance Solution (Propylene						
	Glycol) Instill or	ne unit in both eyes every					
	two hours as nee	eded for DRY EYE					
	SYNDROME O	F UNSPECIFIED					
	LACRIMAL GL	AND " The medication					
	was ordered as a	PRN [as needed]					
	medication and r	not charted as having					
	been administere	ed by staff.					
	A review of the p	policy titled "2.1 Self					
	Administering M	fedications", last					
	reviewed 5/10/10	0, indicated the					
	following:						
	"2. Facility, in	conjunction with the					
		Care Team, should					
		nine, with respect to					
	each resident, wh						
		tion of medications is					
	safe and appropr	riate.					
	3. To ensure safe	e and appropriate					
	Self-Administrat	tion, Facility should					
	educate residents	s to ensure that a resident					
	is able to:						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155799		,	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 02/04/	ETED		
	PROVIDER OR SUPPLIER	AND ASSISTED LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	frequency, and p medications; 3.2 Understar effects of his/ he he/she should he/she experienc 3.3 Correctly apply his/her me 3.4 Correctly in a locked comp  4. Facility shoul resident Self-Ad safely and appro  5. Facility shoul Self-Administrat medication(s) the Self-Administer.  8. If a resident S medications, Fac the Interdisciplin routinely assess physical and visi	store his/her medications partment.  d regularly observe the minister medications priately  d ensure that orders for ion list the specific e resident may						
F 0279 SS=D Bldg. 00	483.20(d), 483.20 DEVELOP COMP PLANS A facility must use	REHENSIVE CARE						

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AND PLAN OF CORRECTION   IDENTIFICATION NUMBER:   155799   B. WING	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) E			(X3) DATE S	3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER  MARION REHABILITATION AND ASSISTED LIVING CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are	AND PLA	AN OF CORRECTION	IDENTIFICATION NUMBER:			00		
MARION REHABILITATION AND ASSISTED LIVING CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are			155799	B. WI	NG		02/04/	2016
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are  PREFIX PREFIX PREFIX COMPLETION TAG  PREFIX TAG  COMPLETION DATE				₹	614 WE	ST 14TH STREET		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are	(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	Ι	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΙΤΕ	COMPLETION
the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are	TAG		·		TAG	DEFICIENCY)		DATE
care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are								
The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.10, including the right to refuse treatment under §483.10(b)(4).  Based on observation, interview, and record review, the facility failed to develop individualized careplans for 1 of 1 residents reviewed for urinary tract infection and isolation practices (Resident #36) and 1 of 1 residents reviewed for medication self-administration (Resident #5)  1. On 2/1/16 at 12:46 p.m., Resident #36 was observed sitting in her room. There was a sign on her door indicating isolation precautions were in place.  Resident #36 had a current, 11/23/15, quarterly Minimum Data Set (MDS) assessment indicating she was moderately cognitively impaired and was		care plan for each measurable object meet a resident's mental and psych identified in the color that are to be furn the resident's high mental, and psych required under §4 that would otherw §483.25 but are no resident's exercise including the right §483.10(b)(4). Based on observer record review, the develop individual residents review infection and isconfection	resident that includes are stives and timetables to medical, nursing, and osocial needs that are emprehensive assessment.  It describe the services as a services are the practicable physical, prosocial well-being as a services are be required under of provided due to the ender of rights under \$483.10, and the facility failed to the ender of the end of the ender of the end of th	F 02	79	Corrective action for residents affected by the alleged deficient practice. Care plans for residents and 5 have been updated. Identification of other residents affected and corrective action: Reside have the potential to be affected by the alleged deficient practice. Current residents' care plans will reviewed and updated to reflect their individual	e: 36 d. nts nt be	03/05/2016

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	COMPLETED	
		155799	B. WING 02/04/20		02/04/2016	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	R			ST 14TH STREET	
MARION	REHABILITATION	AND ASSISTED LIVING CENTER	!		N, IN 46953	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	occasionally inc	ontinent of urine.			Systemic changes to	
					ensure that alleged	
	Review of Resid	lent #36's clinical record			deficient practice does no	ot
	began on 2/1/16	at 1:25 p.m. A urine			recur: Licensed nursing	
	culture, dated 1/2	21/16 and provided by			staff will be educated on	the
	the DON on 2/4/	/16 at 9:54 a.m.,			care plan process.	
	indicated Reside	ent #36 had vancomycin				
	resistant enteroc	occus (an anti-biotic			Monitoring of the corrective	
		m). There was no			action: the DON or licens	ed
	careplan in the resident's clinical record				designee will audit	
	regarding her urinary tract infection or for isolation practices.				residents, during clinical	
					meeting, with new needs	for
					changes 5 times per wee	k
	During an interv	iew, on 2/2/16 at 10:10			for 4 weeks, then weekly	for
	_	ndicated staff obtained			8 weeks, then monthly for	r 3
	1				months to ensure residen	nt's
		dualized plans of care on			needs are reflected in	
		e application on facility			accordance with the plan	of
	issued iPods.				care. Results of audits wi	
	   During an interv	iew, on 2/4/16 at 9:42			be reviewed monthly at the	ne
	_	nd Nurse Consultant			QA&A meeting for 3	
		ad not been a careplan			months or until a consiste	ent
		e resident's urinary tract			pattern of compliance is	
		•			achieved.	
		solation practices.				
		servation of Resident #5's				
	room on 01/28/2	-				
		was observed sitting on				
		e with a bottle of Systane				
	eye drop solution					
	manufacturers ex	•				
		sident indicated her				
	doctor had told h	ner she could keep the				
	medication at he	r bedside to use as				
	needed. The dire	ections on the pharmacy				

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	OF CORRECTION  OF CORRECTION  155799	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction  00	(X3) DATE SURVEY COMPLETED 02/04/2016
	PROVIDER OR SUPPLIER I REHABILITATION AND ASSISTED LIVING CENTER	614 WE	ADDRESS, CITY, STATE, ZIP CODE EST 14TH STREET N, IN 46953	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	bottle indicated to instill one drop into each eye once per day. Resident #5 indicated that she used the eye drops several times during the day, every day as indicated by her doctor.			
	During an observation of Resident #5 on 02/02/2016 at 8:19 a.m., the pharmacy bottle containing Systane eye drop solution was observed sitting on the bedside table.			
	A review of the medical record for resident #5 began on 01/28/2016 at 9:58 a.m. It indicated Resident #5's diagnosis included but were not limited to: osteoporosis, major depressive disorder, urinary incontinence, dry eye syndrome. The most current Minimum Data Set assessment (MDS), dated 12/30/2015, indicated the resident was cognitively intact. There was no care plan indicating Self-Administration for Resident #5.			
	During an interview with LPN #1 on 02/01/2016 at 9:28 a.m., she indicated she was the nurse for the E Hall that day and that there was not a resident who self-administered their medication on that hallway.			
	During an interview with the Director of Nursing (DON) on 02/02/2016 at 9:46 a.m., she indicated that there was not an			

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155799			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/04/2016	
	PROVIDER OR SUPPLIEF	AND ASSISTED LIVING CENTE	614 W	ADDRESS, CITY, STATE, ZIP CODE EST 14TH STREET DN, IN 46953		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
	self-administrati to 2/1/2016.  A review of the Administering N 5/10/10 indicate "2. Facility, ir Interdisciplinary assess and determent assess and determent to 2/1/2016.	conjunction with the Care Team, should mine, with respect to hether tion of medications is				
F 0282 SS=D Bldg. 00	CARE PLAN The services prove facility must be propersons in accord written plan of car Based on observe interview, the far residents with ble three times a day antihypertensive administration recordered by the presidents review medications, (Recorded)	ation, record review and cility failed to ensure ood pressure monitoring prior to medication eceived those services as hysician for 1 of 5 ed for unnecessary	F 0282	F282 Corrective action for residents affected by the alleged deficient practice: Resident 14 vital signs ar being monitored prior to medication administration of medications with parameters. As soon as the facility received notification	e i he	

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followed standards for glucose testing for

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>			COMPLI	ETED
		155799	B. WING			02/04/2016	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				EST 14TH STREET		
MARION	REHABII ITATION	AND ASSISTED LIVING CENTER			N, IN 46953		
	REHABILITATION	AND AGGIGTED EIVING GENTEN	•	WAINO			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	2 of 2 residents of	observed on "D" hall.			from the surveyor regardi	ng	
	(Resident #30 and #110)				the improper glucose		
					monitoring, the nurse was		
	Findings include	:			immediately educated on		
	1. The clinical record of Resident #14 was reviewed on 2/1/16 at 2:35 p.m.				the correct procedure for		
					glucose monitoring.		
					gideose monitoring.		
	Diagnoses included, but were not limited to, pleural effusion, edema, heart failure, chronic obstructive pulmonary disease with acute exacerbation, cardiomegaly,				Identification of other		
					residents affected and		
					corrective action: resider	its	
					who receive glucose		
	heart disease, atrial fibrillation, diabetes				monitoring or have		
	mellitus type II,	anxiety disorder and			medications with		
	anemia.	3			parameters have the		
	anomia.				potential to be affected by	,	
	Doored marriage in	diagted the physician			the alleged deficient		
		ndicated the physician			practice.		
		wing on 12/22/15:			practice.		
	_	antihypertensive			0		
	medication] table				Systemic changes to		
	[milligrams] by	mouth three times a day			ensure that alleged		
	for HTN [hypert	ension]; CHF	deficient practice does not			t	
	. –	t failure] Hold if Systolic			recur: Licensed nursing		
		ure] > [greater than]			staff have been educated		
	100.	arej - [greater than]			on the proper procedure f	or	
	100.				glucose monitoring and		
		1 337 1 1 1 1 2 2 1			administering medication		
		'Weights and Vitals			with parameters		
	Summary " pr						
	medication admi	nistration record from			Monitoring of the correctiv	,,	
	1/1/16 through 1	/21/16 provided by the			Monitoring of the corrective		
	_	ing (DON) on 2/1/16 at			action: the DON or license	ea	
		ted the following:			designee will audit new		
	2.20 p.m. maicu	me rone mag.			physicians orders, during		
	o Docidont #141	s blood prossure was			clinical meeting, 5 times p	er	
		s blood pressure was			week for 4 weeks, then		
	assessed one time a day on 1/2/16,				weekly for 8 weeks, then		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155799		ĺ	JILDING	nstruction <u>00</u>	(X3) DATE COMPL <b>02/04</b> /	ETED	
	PROVIDER OR SUPPLIER	AND ASSISTED LIVING CENTER	ł	614 WE	ADDRESS, CITY, STATE, ZIP CODE IST 14TH STREET N, IN 46953		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	1/3/16, 1/4/16, 1 1/10/16 through 1/19/16, and 1/20 b. Resident #14 assessed twice di 1/9/16, 1/16/16, c. Resident #14' assessed three tin Cardizem admin  During an interv Nursing (DON) i 2/2/16 at 9:13 a.i the supplemental monitoring dropp medical adminis 1, 2016 and did in document or asse pressure prior to administration for The DON furthe should have asse blood pressure as  A review of a "Co by the DON on 2 created on 2/4/20 following:  A review of the p	/6/16, 1/7/16, 1/8/16, and 1/15/16, 1/17/16, 0/16.  's blood pressure was aily on 1/1/16, 1/5/16, 1/18/16 and 1/21/16.  s blood pressure was not mes a day prior to istration as ordered.  iew with the Director of and the Administrator on m., the DON indicated blood pressure ped off the electronic tration record on January not trigger the nurse to ess Resident #14's blood Cardizem medication or part of January 2016. In indicated the nurse(s) are indicated the nurse(s) sesed and documented the sordered.  General Note" provided 2/4/16 at 1:05 p.m. and 016, indicated the		TAG	monthly for 3 months. Results of audits will be reviewed monthly at the QA&A meeting for 3 months or until a consiste pattern of compliance is achieved.	ent	DATE
		CARE MEDICATION TION OPERATING					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	ILDING	00	COMPL	LETED
		155799	B. WIN	NG		02/04/	/2016
			<del></del>	STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8			ST 14TH STREET		
MARION	REHABII ITATION	AND ASSISTED LIVING CENTER			N, IN 46953		
					, 10000		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL	1	PREFIX	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	ROPRIATE	
TAG		LISC IDENTIFYING INFORMATION)		TAG	DLI ICILIACI )		DATE
		UIDELINE.", provided					
	_	nsultant on 2/2/16 at 9:47					
	a.m., indicated the following:						
	"PRACTICE:	Medications will be					
	given in a manne	er which will prevent					
	error related to the	he prescribing,					
		administration, or					
	monitoring of a						
	C						
	PROCEDURE	3:					
	Check nertiner	nt vital signs such as HR					
	•	BP (blood pressure) prior					
	· ·	ations with parameters.					
	to giving incurca	utons with parameters.					
	No further infer	mation was provided by					
	exit on 2/4/16.	manon was provided by					
		liantian administration					
	_	dication administration					
	_	inning on 2/3/16 at 10:33					
	a.m., the followi	ng was observed:					
		ed two glucose testing					
	*	torage vial and placed					
	them in a small j	plastic medication cup.					
	She then placed	the cup on top of the					
	medication cart	and opened the top					
		rt. Inside the drawer,					
		astic cup contained one					
	•	•					
	glucose testing strip. LPN #30 indicated she had left the strip there following the						
		pass due to not having a					
	vial of strips on	her medication cart.					
			1				I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155799		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			X3) DATE SURVEY  COMPLETED  02/04/2016		
	PROVIDER OR SUPPLIER		<u>                                     </u>	614 WE	DDRESS, CITY, STATE, ZIP CODE ST 14TH STREET N, IN 46953	02/01/	2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
IAU	LPN #30 removes strip from the me the cup containing cart. She proceed room, carrying a the test strip. LPD blood glucose test the test strip that plastic medication removed her glowalked to the number of test strip from the medication cart, She proceeded to LPN #30 perform Resident #110 with the performed at Resident #110, using the process of the performed the performed the performed the process of the cup.	ed the cup containing the edication cart and placed ing the two strips into the ded to Resident #14's glucometer, gloves, and N #30 then performed a set on Resident #14, using had been stored in the on cup. She then eves, left the room, and		TAU			DATE
	stored in the orig	trips should remain ginal container.  ument, titled " USER'S Even Care G2 Blood					
		ring System, provided by					

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155799	B. WING		02/04/2016
	ROVIDER OR SUPPLIER	AND ASSISTED LIVING CENTER	614 WE	ADDRESS, CITY, STATE, ZIP CODE EST 14TH STREET N, IN 46953	
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	The Company of the Company of	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	DATE
F 0322	p.m., indicated the "IMPORTANT vial cap of the teafter each use. It the original bottle."	Itant on 2/3/16 at 2:59 ne following:  T: Immediately close the st strip bottle tightly  Keep the unused strips in e. DO NOT leave any e the bottle while not in			
SS=D Bldg. 00	NG TREATMENT/ EATING SKILLS Based on the come a resident, the facility of the come and resident, the facility of the company o	ulcers and to restore, if	F 0322	F322 Corrective action for residents affected by the alleged deficient practice Corrective action for	03/05/2016

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155799	B. WI	NG		02/04/	/2016
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	8		l	ST 14TH STREET		
MARION	REHABILITATION	AND ASSISTED LIVING CENTER			N, IN 46953		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	· ·		DATE
	#51).				resident 51 cannot be		
					accomplished as it occur		
	Findings include	::			in the past As soon as		
					facility received notification		
	During a medication administration				from the surveyor regard	ing	
	observation, beginning on 2/3/16 at 11:59				the improper medication		
	a.m., the following was observed:				administration for a g-tub		
					the nurse was immediate	ly	
	LPN #30 entered Resident # 51's				educated on the correct		
	bathroom and donned gloves. Hand				procedure for g-tube		
	hygiene was not performed. LPN #30				medication administratior	٦.	
	1 1	ups, one containing a					
	•	Etramadol 50 mg (pain			Identification of other		
		n water from the sink.			residents affected and		
	· · · · · · · · · · · · · · · · · · ·	the items to Resident			corrective action: resider	nts	
					who receive medications		
		d placed them on the end			thru g-tubes have the		
		#51 was in bed, with			potential to be affected b	У	
	_	unning into a port on her			the alleged deficient		
		e continuously from a			practice.		
		drew 40 milliliters of			•		
	_	arge piston syringe. She			Systemic changes to		
	•	parate port on Resident			ensure that alleged		
		y tube, pushed the water			deficient practice does no	ot	
	into the port with	h the syringe, and closed			recur: Licensed nursing		
	the port. LPN #3	30 then drew up the			staff have been educated	ı	
	water containing	the tramadol tablet,			on proper g-tube care an		
	opened the port,	pushed the water into the			medication administration		
		inge, and closed the port.			saisaasii aaiiiiiloaaaioi		
		p 30 milliliters of water			Monitoring of the correcti	ve	
		ned the water into port			action: the DON or licens		
	with the syringe, and closed the port.				designee will observe	.cu	
	The enteral feeding continued to run into				_	1	
	_						
	die gasifosionly	tude from the pump.			, ,		
	The enteral feed				medication administration via g-tube by licensed nurses. 3 times per week		

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155799		ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 02/04/2016		
	ROVIDER OR SUPPLIER REHABILITATION AND ASSISTED LIVING CENTER					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
F 0323	LPN #30 indicated she stopped the tube feeding at times and used that port, and other times, she used the alternate port. She further indicated she pushed the fluids into the tube with the syringe because they went in easily.  During an interview, in 2/3/16 at 2:01 p.m., the DON and Nurse Consultant indicated the fluids should not be pushed in with a syringe.  Review of a policy, titled " COVENANT CARE MEDICATION ADMINISTRATION OPERATING STANDARD GUIDELINE", dated 12/2012 and received from the DON on 2/3/16 at 2:30 p.m., indicated the following:  "Enteral feedingsWash hands and don glovesCheck for placement and tube patencyDo not add medication directly to an enteral feeding formulaPrior to administering med, stop the feeding and flush the tube with a minimum of 15mL waterAdminister medicationsResume feeding as ordered"  3.1-44(a)(2)		for 4 weeks, then weekly 8 weeks, then monthly for months to ensure proper procedure is followed per policy.  Results of audits will be reviewed monthly at the QA&A meeting for 3 months or until a consister pattern of compliance is achieved.	r 3		
SS=D	FREE OF ACCIDENT					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED
		155799	B. WI	NG	<u> </u>	02/04/	2016
				CTDEET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	-					
MADION		AND ACCIOTED LIVING CENTED			EST 14TH STREET		
MARION	REHABILITATION	AND ASSISTED LIVING CENTER		WARIO	N, IN 46953		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
Bldg. 00	HAZARDS/SUPER	RVISION/DEVICES					
	The facility must e	nsure that the resident					
		ins as free of accident					
	•	sible; and each resident					
	receives adequate						
		s to prevent accidents.					
		ation, interview, and	F 03	323	F323		03/05/2016
	record review, th	e facility failed to ensure			Corrective action for		
	medications were	e stored securely for 1 of			residents affected by the		
	30 residents revi	ewed for room safety			alleged deficient practice:		
		his practice had the			Corrective action for		
	· ·	-			residents 14 and 110		
	potential to affec				cannot be accomplished	00	
	_	vior of 14 residents			l '	as	
	residing on the "	E" Hall. Furthermore,			it occurred in the past.		
	the facility failed	l to ensure sharps devices			Resident 5's expired		
	were disposed of	Eproperly for 2 of 2			medication was		
	residents observe				immediately removed froi	m	
		idents #14 and #110).			the resident's room.		
	monitoring (Resi	dents #14 and #110).					
					Identification of other		
	_	cation administration			residents affected and		
	observation, begi	inning on 2/3/16 at 10:33				at o	
	a.m., the following	ng was observed:			corrective action: resider	แร	
					who receive glucose		
	I PN #30 nerforn	ned a finger-stick on			monitoring or have		
	_	th a lancet and tested the			medications at bedside		
					have the potential to be		
	`	glucose. LPN #14			affected by the alleged		
	discarded the lan	cet in the trash can next			deficient practice.		
	to Resident #14's	s bed. LPN #30 then					
	returned to the m	nedication cart.			Systemic changes to		
					'		
	   At 10:30 am   I	PN #30 proceeded to			ensure that alleged		
	-	•			deficient practice does no	ot	
	Resident #110's i				recur: Nursing staff have		
		er-stick on Resident			been educated on dispos	al	
	#110 with a lance	et. LPN #30 discarded			of sharps and securing		
	the lancet in the	trash can next to			medications of residents		
			1		1		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED
		155799	B. WI	NG		02/04/	/2016
				CTDEET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			EST 14TH STREET		
MARION	REHABII ITATION	I AND ASSISTED LIVING CENTER		1	N, IN 46953		
	1				14, 114 40900		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
ing		bed and tested the		1710	who self-administer.		DATE
					Resident who		
	resident's blood glucose.						
	LPN #30 indicated she would not have				self-administer medicatio	IIS	
					will be educated on		
	performed anything differently.				securing their medication	۱.	
	Daview of a re-1	lian titled "COVENANT			Monitoring of the correcti	ve	
	Review of a policy, titled "COVENANT CARE MEDICATION				action: the DON or licens		
		ATION TION OPERATING			designee will audit		
					resident's room who self		
	STANDARD GUIDELINE", dated				administer medications,		
	12/2012 and provided by the DON on				times per week for 4 week		
	_	.m., indicated the			then weekly for 8 weeks,		
	following: "Blood Glucose Monitoring-				then monthly for 3 month		
	Properly dispo	ose of supplies"			to ensure medications ar		
					secured as required as w		
	Review of a doo	-			as check expiration dates		
		DED INFECTION			such medications. The		
		ACTICES TO PREVENT			DON or licensed designe	ee	
	PATIENT-TO-				will observe glucose testi		
	TRANSMISSIO	ON OF BLOODBORNE			5 times per week for 4	9,	
	PATHOGENS"	, published by the Centers			weeks, the weekly for 8		
	for Disease Cor	ntrol and Prevention, and			weeks, then monthly for	3	
	provided by the	Administrator on 2/3/16			months to ensure proper		
	at 4:13 p.m., inc	dicated the following:			disposal of lancets. Resu		
	"Dispose of use	d fingerstick devices and			of audits will be reviewed		
	_	oint of use in an approved			monthly at the QA&A	•	
	sharps containe				meeting for 3 months or		
	•	servation of Resident #5's			until a consistent pattern	of	
	_	2016 8:22 a.m., a			compliance is achieved.	J1	
		e was observed sitting on			Compliance is achieved.		
	a table at bedside with a bottle of Systane						
eye drop solution inside with an expiration date of 12/2015. The resident							
		octor had told her she					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155799		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 02/04/2016	
	PROVIDER OR SUPPLIER	AND ASSISTED LIVING CENTER	614 WI	ADDRESS, CITY, STATE, ZIP CODE EST 14TH STREET DN, IN 46953	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	to use as needed pharmacy bottle drop into each ey Resident #5 indi- eye drops severa every day as indi-	The directions on the indicated to instill one we once per day. Cated that she used the l times during the day icated by her doctor.			
	bottle containing	19 a.m., the pharmacy Systane eye drop erved sitting on the			
	Resident #5 bega a.m The reside but were not lim major depressive incontinence, dry most current Min assessment (MD	medical record for an on 01/28/2016 at 9:58 ent's diagnosis included, ited to osteoporosis, e disorder, urinary y eye syndrome. The nimum Data Set S), dated 12/30/2015, ident was cognitively			
	02/01/2016 at 9: indicated the doc have her prescrib bedside. The pha observed on the with the Residen and indicated ins	iew with Resident #5 on 40 a.m., she again etor told her she could bed eye drops at her armacy bottle was bedside table and labeled t's First and Last name side was Systane eye he directions indicated to			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155799	B. W	ING		02/04/	2016
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				ST 14TH STREET		
MARION	REHABILITATION	AND ASSISTED LIVING CENTER	₹		N, IN 46953		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	instill one drop p	er eye every two hours.					
	The lid of the ph	armacy bottle came off					
	easily and there	was a bottle of Systane					
	Eye Drops.						
	A review of a pl	hysician order sheet for					
	Resident #5, date	ed 11/13/2015 provided					
	by the Business	Office Manager (BOM)					
	on 02/01/2016 at	t 12:59 p.m., indicated:					
		•					
	1. Artificial Tear	s as needed during					
	daytime. (may k	•					
	2. Systane gel @	* '					
	3. Restasis BID						
	J. Restasts BID						
	A review of the i	policy titled 5.3 storage					
	and expiration of						
	_	nges and needles, last					
	" "	rovided by the nurse					
	-	2/2016 at 10:47 a.m.,					
	indicated the foll	· · · · · · · · · · · · · · · · · · ·					
	"4. Facility sho	•					
	_						
	medications and						
		been retained longer than					
		y manufacturer or					
	supplier guidelin						
		dication Storage:					
	13.1 facility s						
	_	de bedside medications					
	or biologicals wi	thout a physician/					
	prescriber order	and approval by the					
	interdisciplinary	care team and facility					
	administration.						
	13.2 Facility	should store bedside					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155799		A. B	A. BUILDING 00  B. WING			COMPLETED 02/04/2016	
	PROVIDER OR SUPPLIER	AND ASSISTED LIVING CENTE	ΞR	614 WE	ADDRESS, CITY, STATE, ZIP CODE EST 14TH STREET N, IN 46953		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
		oiologicals in a locked thin the resident's					
	3.1-45(a)(2)						
F 0431 SS=D Bldg. 00	& BIOLOGICALS The facility must e services of a licen establishes a syst and disposition of sufficient detail to reconciliation; and records are in orde	employ or obtain the used pharmacist who seem of records of receipt all controlled drugs in enable an accurate didetermines that drug er and that an account of is is maintained and					
	must be labeled in accepted profession include the appropriate the appropriate include the appropriate for the second sec	cals used in the facility n accordance with currently onal principles, and priate accessory and tions, and the expiration able.					
	the facility must st biologicals in lock proper temperatur	h State and Federal laws, tore all drugs and ed compartments under re controls, and permit only anel to have access to the					
	permanently affixe storage of controll Schedule II of the Abuse Prevention	provide separately locked, ed compartments for led drugs listed in Comprehensive Drug and Control Act of 1976 ubject to abuse, except					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155799	B. WI	NG		02/04/	2016
NAME OF B	AD CAMPED OD GARDA IED		<u> </u>	STREET.	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			614 WE	EST 14TH STREET		
		AND ASSISTED LIVING CENTER		MARIO	N, IN 46953		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	-	ses single unit package					
	drug distribution systems in which the quantity stored is minimal and a missing						
	dose can be readi						
		ation, interview, and	F 04	131	F431 Corrective action for		03/05/2016
	record review, th	ne facility failed to ensure			residents affected by the alleg		
	· ·	were free of loose pills			deficient practice: The expired insulin and loose pills were		
		ications for 1 of 3			immediately destroyed. Reside	ent	
	medication carts				5's expired eye drops were		
		ge (North "E" Hall cart).			removed from the resident's		
		d the potential to affect	room. A locked box has beel				
	-	ose medications were		provided to the resident for			
		th cart of 14 residents			storage of her medication. Identification of otl	her	
					residents affected and correcti		
		E" Hall. Furthermore,			action: residents have the		
	1	I to ensure medications			potential to be affected by the		
		rely for residents who			alleged deficient practice. The	;	
		d medications (Resident			medication carts have been		
		ce had the potential to			inspected for loose pills and expired medications which we	re	
	affect 1 resident	with wandering behavior			then destroyed. Systemic		
	of 14 residents re	esiding on the "E" Hall.			changes to ensure that alleged	t	
					deficient practice does not rec		
	Findings include	¢			Licensed nursing staff have be		
					educated on medication storage and disposal of expired	ge	
	1. During medica	ation storage			medications. Monitoring of the	غ د	
	_	inning on 2/2/16 at 9:22			corrective action: The DON or		
	_	locked the north "E" hall			licensed designee will audit the	е	
	•	ion. A vial of Novolog			med carts 5 times per week fo		
		rved in the top drawer of			weeks, then weekly for 8 weeks then		
		with Resident #6's name			then monthly for 8 weeks, ther monthly for 3 months to ensure		
	•	te of 1/29/16. During			expiration dates are within	-	
		•			guidelines. Results of audits w	ill	
		the remaining drawers, the				be reviewed monthly at the QA&A	
ı		was found to contain 3			meeting for 3 months or until a		
		ghout the cart. RN #33			consistent pattern of compliant is achieved.	ce	
		ulin and pills should			is deflicated.		
	have been dispos	sed of.	1				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155799		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION  00	COM	TE SURVEY  MPLETED  04/2016	
	PROVIDER OR SUPPLIER	AND ASSISTED LIVING CENTER	614 \	ET ADDRESS, CITY, STATE, ZIP O WEST 14TH STREET KION, IN 46953	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	began on 2/2/16 #6 had current pl	ent #6's clinical record at 10:30 a.m. Resident hysician's orders for per sliding scale four				
	administration re February, 2016 i	ent #6's medication ecords for January and indicated Resident #6 had g insulin on 1/30/16, and 2/2/16.				
	room on 01/28/2 pharmacy bottle a table at bedside eye drop solution expiration date of indicated her door could keep the meto use as needed pharmacy bottle drop into each eye Resident #5 indice eye drops severa	was observed sitting on e with a bottle of Systane in inside with an f 12/2015. The resident etor had told her she hedication at her bedside. The directions on the indicated to instill one				
	02/02/2016 at 8: bottle containing	vation of Resident #5 on 19 a.m., the pharmacy Systane eye drop erved sitting on the				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155799		,	LDING	NSTRUCTION  00	(X3) DATE COMPL 02/04/	ETED	
	PROVIDER OR SUPPLIER	AND ASSISTED LIVING CENTER	٠	614 WE	DDRESS, CITY, STATE, ZIP CODE ST 14TH STREET N, IN 46953		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IATE	(X5) COMPLETION DATE
	o2/01/2016 at 1: she knew Reside her bedside but of expired. LPN ## #5's room, check and indicated the eye drop solution were expired and room.  Review of a poli Expiration of Mod 1/1/13, and prov Consultant on 2/ indicated the following th	y should ensure that e stored in an orderly en retained longer than dication Storage:					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155799		A. BUILDING 00  B. WING			COMPLETED 02/04/2016		
	ROVIDER OR SUPPLIER	AND ASSISTED LIVING CENTER	2	614 WE	.DDRESS, CITY, STATE, ZIP CODE ST 14TH STREET N, IN 46953		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
		iologicals in a locked thin the resident's					
F 0441 SS=D Bldg. 00	Infection Control P provide a safe, sar environment and to	S stablish and maintain an Program designed to nitary and comfortable					
	Control Program u (1) Investigates, co infections in the fa (2) Decides what p isolation, should be resident; and (3) Maintains a rec	stablish an Infection Inder which it - ontrols, and prevents					
	determines that a prevent the spread must isolate the re (2) The facility must a communicable d lesions from direct their food, if direct disease.  (3) The facility must be a prevent a p	ction Control Program resident needs isolation to d of infection, the facility					

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED
		155799	B. WI	NG		02/04/	2016
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			EST 14TH STREET		
MARION	REHABILITATION	AND ASSISTED LIVING CENTER		MARION, IN 46953			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ashing is indicated by					
	accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.						
	Based on observer record review, the proper infection followed, in regal handling, Mantobeing read for 1 immunizations (personal protection precautions not for 1 of 1 resident Vancomycin - R (VRE) (Resident #34), sanitization handwashing. (In This deficiency)	followed by facility staff int in isolation for esistant Enterococci t #36) (Activity Aide in of glucometer and Resident #30 and #110). had the potential to affect ts residing in the facility.	F 04	141	F441 Corrective action for residents affected by the alleg deficient practice: resident 110 PPD documentation cannot be corrected as it occurred in the past. When linen handling and PPE usage issues were broug to the facility's attention by the surveyor, the indicated employees were educated on proper linen and PPE usage procedure. Identification of other residents affected and correct action: current residents have potential to be affected by the alleged deficient practice. Systemic changes to ensure alleged deficient practice does not recur: Nursing staff have been educated on PPD administration/documentation procedure. The laundry staff have been educated on linen handling the procedure in the staff of the s	c)'s e d ght er ive the that	03/05/2016
	handling on D ha	servation of clean linen all by laundry aide #3 on owing was observed:			procedure. The activity staff had been educated on PPE usage procedure. Monitoring of the corrective action: the DON or licensed designee will observe handwashing on 3 employees	ave	
	a. At 9:25 a.m.,	laundry aide #31			times per week for 4 weeks, the		
	removed clean li	inen from the laundry			weekly for 8 weeks, then mon	thly	
	cart and held a p	ile of clean linen with			for 3 months to ensure proper		
	one hand on top	and one on the bottom of			handwashing procedure during care. The DON or licensed	g	
	the pile. The cle	ean linen was held against			designee is will review new		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155799	r í	JILDING	nstruction 00	(X3) DATE : COMPL 02/04/	ETED
	PROVIDER OR SUPPLIER	AND ASSISTED LIVING CENTER	2	614 WE	ADDRESS, CITY, STATE, ZIP CODE IST 14TH STREET N, IN 46953		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	her chin as she dilaundry to room  b. At 9:29 a.m., removed clean licart and held a pwith one hand or bottom of the pill held against her clean laundry to  During an interv#31 and the Direst Services on 2/3/aide #31 indicated away from the both hands. Laur indicated she the clean linens again linens.  The Director of lindicated laundry the clean linen as would try to put residents' closets He further indicated.	laundry aide #31 nen from the laundry ile of folded clean linen n top and one on the e. The clean linen was torso as she delivered the room D136.  iew with laundry aide ctor of Environmental l6 at 2:13 p.m., laundry ed laundry was to be held ody and held only with ndry aide #31 further rught she could carry nst her body but not dirty  Environmental Services y aide #31 would touch gainst her body when she them away in the , because she was short. itted she had no problem the linen closets on the			admission PPD process, 5 timper week for 4 weeks, then weekly for 8 weeks, then mon for 3 months to ensure PPD administration and documentation. The DON or licensed designee will observe PPE usage for any resident in isolation, 5 times per week for weeks, then weekly for 8 week then monthly for 3 months to ensure proper PPE usage. Results of audits will be review monthly at the QA&A meeting 3 months or until a consistent pattern of compliance is achieved.	thly  4 Ks,	
	Administrator or	n 2/3/16 at 2:35 p.m., she inen was to be held away					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155799		` <i>′</i>	LDING	NSTRUCTION  00	(X3) DATE COMPL <b>02/04</b> /	ETED	
	PROVIDER OR SUPPLIER	AND ASSISTED LIVING CENTER	2	614 WE	DDRESS, CITY, STATE, ZIP CODE ST 14TH STREET N, IN 46953		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	·ΤΕ	(X5) COMPLETION DATE
	2. The clinical rates was reviewed on Diagnoses included to, end stage rene elevated white band dependence clinical record in was admitted on Record review in physician order farm. May have 2 S [purified protein to determine tube every day shift fountil finished RE after administrat	record of Resident #110 2/3/16 at 10:09 a.m. ded, but were not limited al disease, pneumonia, lood count, hypertension on renal dialysis. The dicated Resident #110 11/2/15 from a hospital.  dicated on 11/2/15, a for the following: tep Mantoux PPD derivative] [a skin test erculosis] on Admission or 1 Administrations EAD PPD 48 Hrs, [hours] ion - Step 1. Document at's Immunization					
	"Medication Adı (MAR) indicated	november, 2015 ministration Record" I no result was recorded m 11/2/15 through					
	Staff Developme a.m., she indicate PPD Step 1 at th it should have be	ent on 2/2/16 at 10:38 ed Resident #110 had the e hospital on 11/2/15 and een read on 11/4/15 at the icated it was not read.					

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	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155799	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  OO	(X3) DATE SURVEY COMPLETED 02/04/2016				
	PROVIDER OR SUPPLIER  N REHABILITATION AND ASSISTED LIVING CENTER	614 WE	STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE				
	During an interview with the Director of Staff Development on 2/2/16 at 11:16 a.m., she indicated since October 2015, she had been scheduling the PPD for day shift to be administered and to be read on two days later on the evening shift to ensure the window of 48 hours was met. She further indicated if one person misses a step then the facility would need to start with the Stage 1 PPD.  A review of policy titled "TUBERCULOSIS CONTROL PLAN" provided by the Nurse Consultant on 2/2/16 at 12:57 p.m. indicated the following: "PURPOSE: To minimize employee exposure to, and subsequent infection with, tuberculosis (TB).							
	POLICY: This facility has adopted and will enforce the latest recommendations of the Centers for Disease Control and Prevention (CDC) regarding prevention of occupational transmission of TB among its employees and residents. The following procedures reflect the most recent CDC guidelines published in 2005PROCEDURE:C. ADMISSIONS  1. All residents will be screened on admission for infection with tubercle							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155799		ľ í	UILDING	nstruction <u>00</u>	(X3) DATE COMPL <b>02/04</b> /	ETED	
		AND ASSISTED LIVING CENTER	₹	614 WE	DDRESS, CITY, STATE, ZIP CODE ST 14TH STREET N, IN 46953		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Consultant on 2/indicated the pol "TUBERCULOS indicated no time PPD, but should hours after admi  No further information of the exit on 2/4/16.  3. On 2/1/16 at 14 Assistant #34 was Resident 36's roomed biological based outside of the roomed the resident's room. In the content was Assistant #34 properties as a cart of books of asked by the sure Resident #36's roomed to be changed. Such as the content was a cart of books of asked by the sure Resident #36's roomed to be changed. Such as the content was and gloves in the when she had into but had noticed to be changed. Such as the content was a cart of books of asked by the sure Resident #36's roomed to be changed. Such as the content was a cart of books of asked by the sure Resident #36's roomed to be changed. Such as the content was a cart of books of asked by the sure Resident #36's roomed to be changed. Such as the content was a cart of books of asked by the sure Resident #36's roomed to be changed. Such as the content was a cart of books of asked by the sure Resident #36's roomed to be changed. Such as the content was a cart of books of asked by the sure Resident #36's roomed to be changed. Such as the content was a cart of books of asked by the sure Resident #36's roomed to be changed. Such as the content was a cart of books of asked by the sure Resident #36's roomed to be changed. Such as the content was a cart of books of asked by the sure Resident #36's roomed to be changed. Such as the content was a cart of books of asked by the sure Resident #36's roomed to be changed. Such as the content was a cart of books of asked by the sure Resident #36's roomed to be changed. Such as the content was a cart of books of asked by the sure Resident #36's roomed to be changed. Such as the content was a cart of books of asked by the sure Resident #36's roomed to be changed. Such as the content was a cart of books of asked by the sure Resident #36's roomed to be changed. The content was a cart of books of asked by the sure Resident #36's roomed to be changed.	iew with the Nurse 2/16 at 1:15 p.m., she icy related to SIS CONTROL PLAN" e frame for reading a be read between 48-72					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155799		l í	ILDING	nstruction <u>00</u>	(X3) DATE COMPL 02/04	ETED	
	PROVIDER OR SUPPLIER REHABILITATION	AND ASSISTED LIVING CENTER	₹	614 WE	DDRESS, CITY, STATE, ZIP CODE ST 14TH STREET N, IN 46953		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	E RIATE	(X5) COMPLETION DATE
		e had not reapplied a nor had she re-washed					
	and provided by 9:54 a.m., indica	e culture, dated 1/21/16 the DON on 2/4/16 at ted Resident #36 had stant enterococcus (an ant organism).					
	Resident #36 had a current, 11/23/15, quarterly Minimum Data Set (MDS) assessment indicating she was moderately cognitively impaired and was occasionally incontinent of urine.						
	a.m., the DON at indicated the rest	nd nurse consultant ident was in isolation y infection per CDC s.					
	Precautions", dat by the Admission 2:53 p.m., indica GLOVES AND Gloves should be roomE. After g hygiene, hands s potentially conta surfaces or items gown should be	cy, titled " Contact and 2012, and provided as Director on 2/1/16 at a ted the following: "II. HAND HYGIENEB. as worn when entering the glove removal and hand should not touch minated environmental aIII.GOWNSA. A donned prior to entering the removal of the gown,					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	ULTIPLE CO UILDING	00	(X3) DATE COMPL		
		155799	B. W	ING		02/04/	
NAME OF I	DD OLUDED OD CLIDDI IED		1	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIER				ST 14TH STREET		
MARION	REHABILITATION	AND ASSISTED LIVING CENTER	₹	MARIO	N, IN 46953		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		not contact potentially		mo	<u> </u>		DATE
	_	vironmental surfaces"					
		viroimientai sariaces					
	4. During a med	ication administration					
	_	inning on 2/3/16 at 10:33					
	· ·	ng was observed:					
	LPN #30 applied	l gloves, without					
	performing hand	hygiene, and performed					
	a finger-stick on	Resident #14 with a					
	lancet. LPN #14	discarded the lancet in					
		tt to Resident #14's bed.					
		erformed a blood glucose					
		#14. She then removed					
	_	he room, and walked to					
		n. LPN #30 then					
	_	one at the nurse's station.					
		g the phone call, LPN					
		ched the nurse's station					
	sink and washed	her hands.					
	LPN #30 then do	onned another pair of					
		the glucometer with a					
		and removed the gloves.					
		orm hand hygiene after					
	_	oves. LPN #30 gathered					
	the glucose mete	er and testing supplies.					
	She proceeded to	Resident #110's room.					
	LPN #30 applied	l gloves, without					
	performing hand	hygiene, and performed					
		Resident #110 with a					
		discarded the lancet in					
		at to Resident #110's bed.					
	_	erformed a blood glucose					
	test on Resident	#110.					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155799		A. BUILDING 00  B. WING	HON	COMPLETED 02/04/2016
	PROVIDER OR SUPPLIER  REHABILITATION AND ASSISTED LIVING CENTER	STREET ADDRESS, 614 WEST 14T MARION, IN 46		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX (EAC)	PROVIDER'S PLAN OF CORRECTION TH CORRECTIVE ACTION SHOULD BE 5-REFERENCED TO THE APPROPR DEFICIENCY)	
	LPN #30 then carried the glucometer to the medication cart and while wearing the same pair of gloves, cleaned the glucometer with a disposable wipe. She placed the glucometer on a paper towel and then removed the gloves.  LPN #30 indicated she would not have performed the process differently.  Review of a policy, titled "COVENANT CARE MEDICATION ADMINISTRATION OPERATING STANDARD GUIDELINE", dated 2/2012 and provided by the DON on 2/3/16 at 2:30 p.m., indicated the following: "Blood Glucose MonitoringWash hands and don gloves"  Review of a document, titled "RECOMMENDED INFECTION CONTROL PRACTICES TO PREVENT PATIENT-TO-PATIENT TRANSMISSION OF BLOODBORNE PATHOGENS", published by the Centers for Disease Control and Prevention, and provided by the Administrator on 2/3/16 at 4:13 p.m., indicated the following: "Dispose of used fingerstick devices and lancets at the point of use in an approved sharps container"			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU				ETED
		155799	B. WIN	NG		02/04/	/2016
		<u> </u>	Ь Т	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	R			ST 14TH STREET		
MARION	REHABII ITATION	AND ASSISTED LIVING CENTER			N, IN 46953		
IVIAINION					N, IIN 40933		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	3.1-18(b)						
	3.1-18(e)						
	3.1-18(1)						
	3.1 10(1)						
F 0502	483.75(j)(1)						
SS=D	ADMINISTRATIO	N					
Bldg. 00		provide or obtain laboratory					
Diag. 00		the needs of its residents.					
	The facility is resp	oonsible for the quality and					
	timeliness of the s						
	Based on record	review and interview,	F 05	02	F502		03/05/2016
		d to ensure labs were			Corrective action for		
		of 5 residents reviewed			residents affected by the		
	for lab results. (				alleged deficient practice:		
	101 lab lesuits. (	Resident #31)			Resident 51's labs were	,	
	Findings include	2:			drawn on 2-2.16		
	The clinical reco	ord for Resident #51 was			Identification of other		
		/16 at 10:30 a.m.			residents affected and		
					corrective action: residen	ts	
	_	ne resident included, but			with lab orders have the		
		to, diabetes mellitus			potential to be affected by	.,	
	type II, metaboli	ic encephalopathy,			_	,	
	hypertension, hy	perosmolality and			the alleged deficient		
	hypernatremia. l	ymphocyte depleted			practice.		
		in lymphoma and					
	_	on due to unspecified			Systemic changes to		
		•			ensure that alleged		
		nosis of unspecified			deficient practice does no	ot	
	cerebral artery.				recur: current residents'		
					charts will be audited to		
	A review of Res	ident #51's current					
		indicated, the resident			ensure that labs have been	en .	
		ncluded, "Lab - CMP			drawn as ordered. The		
I	mau oruers mat i	nciuutu,Lau - Civir	ı				I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	ILDING	00	COMPL	ETED
		155799	B. WIN	NG		02/04/	2016
			Ь	CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIE	R					
MADION		I AND ASSISTED LIVING CENTER			ST 14TH STREET		
WARION	REHABILITATION	I AND ASSISTED LIVING CENTER		WARIO	N, IN 46953		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	[comprehensive	metabolic panel] every 3			licensed nursing staff hav	⁄e	
	months due JAN	N [January], APRIL,			been re-educated on the		
		ery night shift every 90			lab testing process.		
	· ·	Date of 07/01/2015Start			тосину р. соссо.		
	• ` '				Monitoring of the correcti		
	Date of 07/29/20	015"			Monitoring of the correction		
					action: the DON or licens		
	"Lab - HGB A	A1C [hemoglobin A1C] [a			designee will conduct a la		
	lab test used to t	test how well diabetes			audit, 5 times per week fo		
	was controlled]	every 3 months due OCT			4 weeks, then weekly for		
	[October] every	night shift every 90			weeks, then monthly for 3	3	
		Date 07/01/2015Start			months to ensure labs are	e	
	Date10/14/20				obtained per MD order.		
	Date10/14/20	13.			Results of audits will be		
					reviewed monthly at the		
	A review of the	labs completed July,			QA&A meeting for 3		
	2015 through Ja	nuary, 2016 for Resident			<u> </u>		
	#51 indicated no	o lab results for a CMP or			months or until a consiste	ent	
	HGB A1c.				pattern of compliance is		
	1102 1114.				achieved.		
	Duning on intern	view with the Director of					
		view with the Director of					
	<b>O</b> \	on 2/1/16 at 1:20 p.m.,					
		e labs CMP and HGB					
	A1c for Residen	nt #51 were not					
	completed.						
	The DON indica	ated she was unaware					
		d uncompleted labs for					
		igh January, 2016. She					
		vere not completed as					
		staff turnover and were					
	not monitored a	s closely with the new					
	staff. The DON	I further indicated the					
	Nurse Practition	ner was notified and a new					
		ved for the labs to be					
	drawn on 2/2/16						
	urawii 011 2/2/10	<i>)</i> .					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE SU	JRVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	A. BUILDING <u>00</u> COMPI		ГED
		155799	B. WING	B. WING 02/04/20		016
			CTREET	ADDRESS CITY STATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIER	₹	STREET ADDRESS, CITY, STATE, ZIP CODE			
MARION REHABILITATION AND ASSISTED LIVING CENTER			614 WEST 14TH STREET			
WARION	REHABILITATION	AND ASSISTED LIVING CENTER	MARION, IN 46953			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5)  COMPLETIC DATE		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG			DATE
	A review of a "Physician's Order Note"					
	provided DON on 2/3/16 at 2:30 p.m. and					
	created on 2/3/2016, indicated the					
	following:					
	"Late Entry for 2/1/2016 at 1340 [1:40					
	p.m.]NP [Nurse Practitioner] updated					
	on missed HGB A1C and CMP. New					
	order to be drawn 2/2/16 then every 3					
	months thereafter"					
	During an interview with the Director of					
	Nursing, Nurse Consultant and the					
	•					
	Administrator on 2/4/16 at 10:15 a.m.,					
	the DON indicated there was no system					
	in place to track labs for long term					
	residents prior to 2/1/16. The Nurse					
	Consultant indicated there was no policy					
	for following physician orders or labs.					
	She indicated it was a standard of care.					
	The state of the s					
	No further information was provided by					
	exit on 2/4/16.					
	3.1-49(a)					
			1	i		

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