STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN REHABILITATION AND HEALTHCARE CENTER	803 S HAMILTON ST SHERIDAN, IN 46069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure survey. Survey dates: November 13, 14, 15, 16, and 19, 2012 Facility number: 000336 Provider number: 155376 AIM number: 100290170 Survey team: Janet Stanton, R.N.--Team Coordinator Heather Lay, R.N. Charles Stevenson, R.N. Joyce Hofmann, R.N. Brenda Nunan, R.N. Census bed type: SNF/NF--68 Total--68 Census payor type: Medicare--14 Medicaid--46 Other-- 8 Total-- 68 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed on	F0000	The preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or correctness of the conslusions set forth on the statment of defiencies, the plan of correction is rpepared solely because of the requiremnts under State and FederalLaw.	

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN REHABILITATION AND HEALTHCARE CENTER	803 S HAMILTON ST SHERIDAN, IN 46069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	November 29, 2012 by Bev Faulkner, R.N.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155376		11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN REHABILITATION AND HEALTHCARE CENTER	803 S HAMILTON ST SHERIDAN, IN 46069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0160 SS=A	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. Based on interview and record review, the facility failed to convey, within 30 days upon death, the balance of a personal funds account to the individual or probate jurisdiction administering the resident's estate for 1 of 2 residents reviewed. [Resident #36] Findings include: On 11/19/12, the personal funds account for Resident #36 was reviewed. The resident was discharged to an acute care hospital on 7/17/12. In an interview on 11/19/12 at 2:15 P.M., the Human Resources Director, who managed the personal funds accounts, indicated the resident had died in the hospital. She did not have an exact date of the resident's death, but was informed later and his account revised on 7/31/12. The "Resident Fund Management	F0160	**F-160** I. Immediately any account of a deceased resident was reviewed to insure prompt accounting and return of funds. The Human Resources employee was educated regarding resident trust accounts. II. Any resident with a Resident Trust account has the potential to beaffected. III Upon notification of a death, the Business Office Manager will determine if a trust account exists and will issue a Check Request for any balance. IV. Human Resources responsible, Administrator or/Business Office Manager to monitor. Completion date 12/19/12	12/19/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN REHABILITATION AND HEALTHCARE CENTER	803 S HAMILTON ST SHERIDAN, IN 46069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Service Statement" form indicated the account was not closed until 10/23/12. The Human Resources Director indicated $52.00 was "sent back to state." In interviews on 11/19/12 at 2:22 P.M., the Human Resources Director indicated she did not know accounts were to be conveyed within 30 days. She indicated she just held on to them in case the resident owed some money. In an interview also at that time, the Executive Director indicated she was aware accounts were to be conveyed within 30 days. 3.1-6(h)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN REHABILITATION AND HEALTHCARE CENTER	803 S HAMILTON ST SHERIDAN, IN 46069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record	F0225	I. #98's concerns were resolved	12/19/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	review, the facility failed to conduct a thorough investigation or report to the state agency an allegation for 1 of 6 residents reviewed for allegations of abuse, neglect and/or injuries of unknown origin (Resident #98). Findings include: Resident #98's record was reviewed on 11/16/12 at 2:21 p.m. Diagnoses included, but were not limited to, spinal stenosis, hypertension, congestive heart failure, and anemia. The 14 day MDS (Minimum Data Set) assessment, dated 9/6/12, indicated the resident's short term and long term memory were okay and the BIMS (Brief Interview of Mental Status) score was 15, indicating the resident was cognitively alert. A "GRIEVANCE/COMPLAINT REPORT," dated 09/04/2012, was reviewed on 11/19/2012 at 1:59 p.m., and indicated, "...1). CNA [CNA #54] addressing res (resident) as [nickname] even though he asked her (not) to. 2). CNA [CNA #55] talks too much & does (not) listen to res. 3). CN (charge nurse) [LPN #44] "snapped" at res. (and) acts bothered to take care of res, bad attitude. 4). CN did (not) empty urinal when		as shown with his signature on the grievance from dated 9/20/12.II Any resident has the potential to be affected. Residents on this assignment will be interviewed by the SSD to determine if other concerns exsist.III All department managers were educated on complete investigation, reporting and suspension by the Administror and SSD. Each grievance will be discussed at team meetings daily and the Administrator will review to insure reportin andinvestigations are completed.IV. Administrator/SSD responsible for manager education. Administratorresponsible for review and SSD responsible for report to QAPI monthly .	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	asked...Spoke w/res (with resident) @ (at) 3 d (day), 7 d, and 16 d from report to ensure coaching was effective & res pleased...09/20/2012 final resolution...." During an interview on 11/14/2012 at 1:10 p.m., Resident #98 stated, "CNAs (Certified Nurse Aides) have been rude." The resident indicated the incident occurred one time after he moved into facility and he reported the incident to the facility. Resident #98 indicated he did not want to provide the names of the CNAs named in the allegation of mistreatment. The resident indicated one of the CNAs provided care to him following the allegation. During an interview on 11/19/2012 at 10:56 a.m., the DoN (Director of Nursing) indicated the allegation of mistreatment was documented on a grievance form. The DoN indicated the incident was investigated by the ADoN (Assistant Director of Nursing). During an interview on 11/19/2012 at 1:59 p.m., the ADoN indicated she completed a grievance report after Resident #98 reported concerns in regard to how he was treated by CNAs. The ADoN indicated she discussed the resident's concerns			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	with the staff named in Resident #98's allegation of mistreatment. The ADoN stated, "staff were coached" on appropriate interactions. She indicated she did not interview other residents to determine if there were additional allegations of mistreatment by staff The ADoN indicated staff named in the allegation were not suspended until the investigation was completed. She indicated the allegation was not reported and stated, "I did not feel like situation was abuse." 3.1-28(c)(d)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.			
	Based on interview and record review, the facility failed to follow their established policies for thoroughly investigating an allegation of verbal abuse and neglect for 1 of 6 residents [Resident #98] reviewed for abuse; and failed to follow their policy in regards to providing abuse training upon hire for 7 of 7 employees. [CNAs #28, 29, 30, 31, 32, 33, and #34] Findings include: 1. On 11/19/12 at 2:30 P.M., abuse training was reviewed for employees. The employees [CNAs] and date of hire are as follows: CNA #28: date of hire: 11/5/12 CNA #29: date of hire: 7/12/12 CNA #30: date of hire: 4/12/12 CNA #31: date of hire: 11/1/12	F0226	I.Orientation will include a documented statement that the individual has received instruction and understands the facility Abuse Policy. Staff members cited will attend an Education of Abuse Policy which includes, investigation, suspension and reporting. Resident #98 has been resolved as shown with signed grievance form on 9/20/12. II Any resident has the potential to be affected. An all staff education session will be given by Administrator and SSD. This inservice will cover policies, definition, investigation, suspension and reporting. III The BOM will do new orientation. per the new guidelines. A test over Abuse Policy will be given prior to floor orientation. The Adm will monitor and	12/19/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	CNA #32: date of hire: 6/14/12 CNA #33: date of hire: 7/12/12 CNA #34: date of hire: 7/13/12 A signed acknowledgment [dated with hire date] was located in each employee file regarding receiving the abuse policies and procedures; however, there was no documentation of abuse training or inservicing upon hire to the facility for the listed employees. On 11/19/12 at 3:15 P.M., in an interview, the Business Office Manager [BOM] indicated that upon hire all new employees are given the facility's abuse policies and procedures to read on their own. The facility schedules inservicing for a later date. The BOM indicated she wasn't aware training had to occur prior to a new employee's first day of contact with residents. On 11/19/12 at 3:30 P.M., the BOM provided an inservicing log, dated 9/30/12, that included the names of CNA #29 [date of hire 7/12/12], CNA #30 [date of hire 4/12/12], CNA #33 [date of hire 7/12/12], and CNA #34 [date of hire 7/13/12].		report monthly to the QI committee. IV. The BOM is responsible for the orientation training. The Administrator and SSD are responsible for the all staff education. The Administrator will monitor and report to QAPI monthly. Completion date: 12/19/12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	At that time, the BOM indicated that CNA #28 [date of hire 11/5/12] and CNA #31 [date of hire 11/1/12] didn't receive abuse inservicing yet. On 11/19/12 at 3:30 P.M., the BOM provided the facility's abuse policies and procedures, dated 3/12. The policies and procedures included, but were not limited to, "Policy: It is inherent in the nature and dignity of each resident... that he/she be afforded the basic human rights, including the right to be free from abuse, neglect, mistreatment, and/or misappropriation of property... the management of the facility recognizes these rights and hereby establishes the following statements, policies, and procedures to protect these rights... Procedure: Training: Employees will receive education and training on Resident Rights, Resident Abuse, and Abuse Reporting during orientation and annually thereafter..." 2. Resident #98's record was reviewed on 11/16/12 at 2:21 p.m. Diagnoses included, but were not limited to, spinal stenosis, hypertension, congestive heart failure, and anemia. The 14 day MDS (Minimum Data Set)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	assessment, dated 9/6/12, indicated the resident's short term and long term memory were okay and the BIMS (Brief Interview of Mental Status) score was 15, indicating the resident was cognitively alert. A "GRIEVANCE/COMPLAINT REPORT," dated 09/04/2012, was reviewed on 11/19/2012 at 1:59 p.m. and indicated, "...1). CNA [CNA #54] addressing res (resident) as [nickname] even though he asked her (not) to. 2). CNA [CNA #55] talks too much & does (not) listen to res. 3). CN (charge nurse) {LPN #44] "snapped" at res. (and) acts bothered to take care of res, bad attitude. 4). CN did (not) empty urinal when asked...Spoke w/res (with resident) @ (at) 3 d (day), 7 d, and 16 d from report to ensure coaching was effective & res pleased...09/20/2012 final resolution...." During an interview on 11/14/2012 at 1:10 p.m., Resident #98 stated, "CNAs (Certified Nurse Aides) have been rude." The resident indicated the incident occurred one time after he moved into facility and he reported the incident to the facility. Resident #98 indicated he did not want to provide the names of the CNAs named in the allegation of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	mistreatment. The resident indicated one of the CNAs provided care to him following the allegation. During an interview on 11/19/2012 at 10:56 a.m., the DoN (Director of Nursing) indicated the allegation of mistreatment was documented on a grievance form. The DoN indicated the incident was investigated by the ADoN (Assistant Director of Nursing). During an interview on 11/19/2012 at 1:59 p.m., the ADoN indicated she completed a grievance report after Resident #98 reported concerns in regard to how he was treated by CNAs. The ADoN indicated she discussed the resident's concerns with the staff named in Resident #98's allegation of mistreatment. The ADoN stated, "staff were coached" on appropriate interactions. She indicated she did not interview other residents to determine if there were additional allegations of mistreatment by staff The ADoN indicated staff named in the allegation were not suspended until the investigation was completed. She indicated the allegation was not reported and stated, "I did not feel like situation was abuse." A March 2012 policy, titled, "Resident			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Abuse," indicated, "...It is inherent in the nature and dignity of each resident...that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, and/or misappropriation of property...No employee may at any time commit an act of physical, psychological, or emotional abuse, neglect, mistreatment, and/or misappropriation of property against any resident...Psychological/Emotional Abuse...Not giving reasonable consideration to a resident's wishes...Neglect...c. Intentional lack of attention to physical needs including, but not limited to, toileting, bathing...Procedure for Reporting Abuse ...All incidents of resident abuse are to be reported immediately to the Clinical Nurse in Charge, Director of Clinical Services, and the Executive Director...The abuse coordinator is responsible for reporting to appropriate officials in accordance with Federal and State Regulations...Investigation of Abuse ...The Abuse Coordinator or his/her designee shall investigate all reports of suspected abuse...The Abuse Coordinator and/or Director of Clinical Services shall take statements from the victim, the suspect(s) and all possible witnesses...Upon completion			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN REHABILITATION AND HEALTHCARE CENTER	803 S HAMILTON ST SHERIDAN, IN 46069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of the investigation, a detailed report shall be prepared...Once completed, the investigation's report shall be reviewed by the Director of Clinical Services, the Abuse Coordinator, and one other Administrative staff member...." 3.1-28(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.			
	Based on observation and interview, the facility failed to ensure staff provided a dignified dining environment to residents [Residents #20, #26, #32, and #65] who required assistance with eating by standing while providing assistance during 1 of 2 meal observations. The facility also failed to ensure staff knocked on the room doors prior to entering for 2 of 2 residents observed. [Residents #56 and #75] Findings include: 1. On 11/13/12 at 12:15 P.M., dining was observed in the South assist dining area. At that time, Residents #20, #26, and #65 were observed being assisted with feeding by CNAs #22 and 23. The CNAs were standing while assisting the residents. On 11/19/12 at 2:45 P.M., in an interview, the DoN indicated she	F0241	I. Staff #22,23,42,56&57 were given an Employee Coaching Plan - Level I, that included education on Resident Dignity and Respect regarding residents #56 and #75.II All residents have the potential to be affected. The use of the Dignity and Privacy Performance Improvement will allow monitoring of Dignity and Respect for all residents.III. A meeting was held with staff on 11/26/12 to discuss the reason staff werestanding while feeding. The solution of removing our horseshoe tables and recon-figuring the seating arrangement to allow for shorter staff to reach residents whileproviding meal service while seated. Also, this allowed a resident with frequentand multiple visitors at meal time to ave adequate space and chairs without impeding the staffs ability to assist residents without standing.All staff were inserviced on Dignity 12/13 and 12/17. Visual reminders to knock,annouce and wait were placed eye level on resident doors and will remain in place for 3 months.IV The Dignity and Privacy Performance	12/19/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	would not expect staff to be standing while assisting residents to eat. She indicated there was no facility policy and she is unsure if staff are trained on that concern. 2. During an observation on 11/13/2012 at 3:47 p.m., CNA (Certified Nurse Aide) #56 knocked on Resident #75's room door, but did not wait to be invited in before entering the room to bring ice water to the resident's bedside. During an observation on 11/15/12 at 2:18 p.m., CNA #56 entered Resident #56's room without knocking on the door. During an observation on 11/16/12 at 3:09 p.m., CNA #57 entered Resident #75's room without knocking. During an interview on 11/16/12 at 3:15 p.m., CNA #57 indicated he should have knocked before entering the room. 3. During dining observations on 11/13/2012 at 12:30 p.m., CNA #42 stood to assist Resident #32 with eating.		Improvement Tool was mondified to include specific monitoring related to knocking and dignified dining environment.This toll will be completed each week for 4 weeks, then monthly x3, then quarterly by the SSD/or disignee. These reviews will be submitted in monthlyQAPI by SSD. Staff responsible, SSD to monitor.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN REHABILITATION AND HEALTHCARE CENTER	803 S HAMILTON ST SHERIDAN, IN 46069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 11/19/2012 at 2:45 p.m., the DoN (Director of Nursing) indicated staff should not have stood to feed a resident.. A facility policy regarding privacy was requested on 11/19/2012 at 10:56 a.m., but was not provided. 3.1-3(t)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the 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 identified in the comprehensive assessment. 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 §483.25 but are not provided due to the resident's exercise of rights 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 ensure Care Plans were developed and/or had specific interventions to be provided by the facility, related to dialysis shunt care, incontinence, pain issues, behaviors, unnecessary medications and vision issues, for 8 of 40 residents reviewed for Care Plan development. [Residents #46, #95, #65, #4, #98, #2, #80, and #50] Findings include: 1. In an interview on 11/16/12 at	F0279	I. The care plan for resident #4 addressing pain/discomfort will be reviewed by 12/13/12 and updated to include non-pharmacological approaches. The care plan addressing vision for resident #50 was reviewed on 12/10/12 and updated to include side effect and efficacy monitoring. A care plan was developed for resident #95 addressing the change in discharge destination. Resident #46 was discharged to home on 12/4/12. The care plan for resident #80 addressing behaviors was updated to include physical aggression and dietary	12/19/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	10:00 A.M., Resident #4 indicated she has some pain all the time, but gets routine medications. The clinical record for Resident #4 was reviewed on 11/16/12 at 10:43 A.M. Diagnoses included, but were not limited to, Gout, osteoarthrosis, shoulder and joint pain, and rotator cuff disorder. A "Discomfort and Pain Identification and Plan of Care" assessment, dated 8/7/11 with an update on 11/15/12, indicated: Moderate to severe pain all over daily; "Tylenol relieves; position as requested." A Care Plan entry, initiated on 5/28/08 and updated on 11/15/12, addressed a problem of: "Need to control chronic pain due to osteoarthritis, gout." The approaches/interventions were listed as: Tylenol 650 mg. [milligrams] QD [every day] and every 4 hours PRN [as needed]--Maximum dose of 4 GM/day; Pain Center (5/22/08); Tramadol [a pain medication]; OsteoBioflex [a joint support supplement]. There was no other Care Plan entry or approaches related to pain and non-medication interventions. The		non compliance. The care plan for #80 addressed mood was updated to include efficacy monitoring. The care plan addressing dental services was updated to include current dental needs. The care plan for #98 addressing pain was updated to include non pharmacological approaches; as well as a dental/oral health plan. The entire care plan for #2 was updated on 12/10/12. A care plan for urinary incontinence was developed for resident #65. The resident profile for each was updaed to reflect any newintervention.II All residents have the potential to be affected. Each resident's care plan will bereviewed on the next scheduled care plan date, to ensure care plans are developed as indicated and have specific interventions.III. Staff was inserviced on care plan development, including specific resident interventions on 12/13/12/and 12/17/12. Care plans will be updated with any noted new problems identified on the 24 hour report, by the MDSC. Care plans will be updated by responsible discipline for problems discussed in the weekly care review meeting. The licensed nurse trranscribing the order will update allcare plans with new or changed orders.The DON or designee will review 24 hour daily report for completion and accuacy. A copy of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident received Tramadol routinely four times a day, and had not taken any of the PRN Tylenol. In an interview on 11/16/12 at 11:20 A.M., LPN #7 indicated she did not know of any non-pharmacological approaches/interventions that were in place to assist resident with pain relief. "We could get a hot pad for her if we needed to." The nurse was not sure if the CNA assignment sheet listed any interventions. In an interview on 11/19/12 at 11:00 A.M., the MDS Coordinator indicated there were two care plans for this resident addressing pain. She referred to the "Discomfort and Pain Identification and Plan of Care" assessment form that indicated "position of comfort." She indicated an interview had been done with the resident, and "That's the only thing the patient mentioned." 2. In an interview on 11/16/12 at 1:10 P.M., Resident #50 indicated she had cataracts. She indicated she had glasses, "but they don't work very well." The resident indicated she had been scheduled for eye surgery last April, but it had to be canceled because she became ill and had to come to the Nursing Home. She		information will be given to the MDSC. Once the careplan has been updated an initialed copy of the 24 hour report will be given to theAdministrator. The care plan for any new problems discussed by IDT in weekly care review will be immediately developed or updated. The DON/or designee will review ALL new physician orders, and initial after verifing the care plan was updated.IV. The MDSC responsible for 24 hour report, DON/designee responsible fornew orders. IDT responsible for identified problems. Administrator andQAPI will monitor by completion of the RAI Process Performance Improvement Tool on 6 residents every month x 3 months, then quarterly thereafter. QAPI committee will reviewmonthly. Addendum: Resident #80's care plan was updated to inculde psychtropic medications on 12/10/12 and included side effect efficacy monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated she was scheduled to see an eye doctor soon, here in the facility. A Care Plan entry, dated 2/28/12, addressed a problem of: "Cataracts, extraction canceled due to hospitalization. Has reading glasses." The only approach listed was: "Vision check declined." There was no other Care Plan entry addressing vision issues, and no approaches/interventions to assist the resident with her current vision issues. In an interview on 11/16/12 at 1:30 P.M., LPN #1 indicated the resident had refused all ophthalmic services. 3. Resident #80 was observed on 11/13/12 at 10:45 a.m. sitting in the dining room recliner. At 12:32 p.m., Resident #80 was observed to be encouraged by staff to taste her dessert cake, but the resident refused. Resident #80 was observed on 11/14/12 at 8:15 a.m., roaming the facility, and then walking with staff back to her unit with her dolls. At 10:35 a.m. and at 11:20 a.m., Resident #80 was observed sitting in			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the recliner across from the main dining room holding her dolls. Resident #80 was observed on 11/15/12 at 12:38 p.m., eating at the 100 hall small dining room with 2 other residents. Review of Resident #80's clinical record on 11/19/12 at 1 p.m., indicated the resident had diagnoses which included, but were not limited to, diabetes, dementia with behavior disturbance, hypertension, rheumatoid arthritis, osteoarthritis, malignant neoplasm of soft tissue and kidney with right nephrectomy, hyperlipidemia, iron deficient anemia, cerebrovascular degeneration, ulcer esophagus with bleed, allergic rhinitis, gastroesophageal reflux disorder, difficulty walking, pathogenic humerus fracture, lack of coordination, joint replacement, chronic pain syndrome, and symbolic dysfunction. Review of Resident #80's Minimum Data Set [MDS] annual assessment, dated 09/28/12, indicated a BIMS score of "3" which indicated the resident was severely cognitively impaired. The assessment indicated the resident was on an antidepressant and a diuretic.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN REHABILITATION AND HEALTHCARE CENTER	803 S HAMILTON ST SHERIDAN, IN 46069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of the Physician's Orders for November 2012 indicated the following medications for Resident #80: "Prilosec 20 mg [milligrams] po [by mouth] qd [every day] (used for GERD) Ultram 50 mg po bid (two times a day) ordered 10/24/12 pain r/t [related to] RA [Rheumatoid Arthritis] MVI [multiple vitamin] 1 po qd (every day) *Remeron 30 mg po qd - just increased 10/25/12 to 30 mg org. order 9/25/12; failed gradual dose reduction [gdr] pto [physician telephone order] dated 8/15/12, reduced to 7.5 mg q hs 7/25/12 (used as an anti-depressant and a appetite stimulant) Tylenol 650 mg po q 4 hrs. [hours] prn [as needed] *Depakote 250 mg po q pm - pharmacy requested gdr (gradual dose reduction) on 5/21/12 per progress notes, physician refused as previous attempts have failed (used as anti-convulsant, mood stabilizer, and anti-migraine agent) Glucagon dc'd [discontinued] 8/16/12 Right chest port 5 ml NS followed by 5 ml [milliliter] Heparin q mo. [every month] - to keep patent d/t [due to] cancer."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of Resident #80's care plans included, but are not limited to, the following: Psychotropic Med. Interventions: VPA [valproic acid] q 3 months Depakote 250 mg q pm The Psychotropic Medication care plan lacked documentation of monitoring for side effects of the Depakote and lacked monitoring of the effectiveness of the medication. The medication of Remeron was not addressed on any of the resident's current Care Plans. 4. The record of Resident #95 was reviewed on 11/13/12 at 1:00 p.m. Diagnoses included, but were not limited to, a history of pulmonary embolism, deep vein thrombosis, diabetes mellitus, heart failure, and bacterial pneumonia. An admission Minimum Data Set Assessment (MDS), dated 6/08/12, indicated Resident #95 had no cognitive deficit, no communication deficits, required minimal assistance for activities of daily living, and had an an anticipated discharge to home.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	An Physical Therapy Initial Evaluation, dated 6/02/12, indicated: " Issues: Difficulty walking, Muscle weakness, Generalized. " Treatment activities included gait training, therapeutic exercise, attention to fall risk, balance, and safety awareness. The identified goal was to "safely return home." A Physical Therapy discharge summary, dated 9/17/12, indicated "Discharge destination Long Term Care. Discharge reason: Highest Practical level achieved." . An Occupational Therapy Initial Evaluation, dated 6/03/12, indicated " Goals: bathing, activity tolerance, standing tolerance, ADLs (activities of daily living) such as laundry/make bed ... An Occupational Therapy Discharge Summary, dated 9/07/12, indicated "Destination: Long Term Care. Reason for DC: Highest Practical Level achieved." A physician's order, dated 9/07/12, indicated "DC (discontinue) skilled pt/ot (physical therapy/occupational therapy) services."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 11/15/12 at 2:30 p.m., LPN #33 indicated Resident #95 was originally admitted with plans to discharge to home after therapy was completed. LPN #33 indicated Resident #95 met all facility goals for return to home, but his wife decided she could not take care of him at home and he would remain in the facility for long term care. During an interview on 11/15/12 2:30 p.m., Resident #95 indicated he believed he had met his goals in therapy and he had no need for further therapy. Resident #95's record contained no Health Care Plan for discharge planning, including, but not limited to, the change in discharge destination from home to Long Term Care, or any services related to facilitating a discharge to home as originally planned. During an interview with the Social Services Director on 11/15/12 at 3:30 p.m., she indicated she had no additional discharge documentation other than what is in the chart. After reviewing the chart, the Social Services Director indicated the chart contained no discharge care plan or formal notification of discharge status.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN REHABILITATION AND HEALTHCARE CENTER	803 S HAMILTON ST SHERIDAN, IN 46069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	5. The record of Resident #46 was reviewed on 11/14/12 at 10:00 a.m. Diagnoses included, but were not limited to, end stage renal disease, hypertension, congestive heart failure, gastro esophageal reflux disease, and convulsions. An admission Minimum Data Set (M.D.S.) assessment, dated 10/11/12, indicated Resident #46 was mildly cognitively impaired, required extensive assistance for all activities of daily living, was frequently incontinent of urine, and was on hemo dialysis. Physician's admission orders 10/04/12 indicated "L (left) AV (arteriovenous) Fistula (an implanted tubular device giving venous access during dialysis). Dialysis M-W-F (Monday, Wednesday, Friday)." Resident #46's record contained no care plan documenting appropriate care, assessment, or documentation of the condition of the implanted arteriovenous fistula. A Health Care plan for "Dialysis" indicated "DX (diagnosis) end stage renal disease." The care plan			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	contained no measurable objectives or timetables to meet the resident's needs to ensure the resident was able to meet their highest practicable physical, mental, and psychosocial well-being while receiving dialysis services. LPN #34 was interviewed on 11/16/12 at 10:40 a.m. She indicated she regularly cared for Resident #46 and that she was familiar with Resident #46's care needs, including her fistula and dialysis care. Following a review of Resident #46's chart, she indicated she could not find any care plan for fistula care. 6. Resident #2's record was reviewed on 11/15/12 at 1:50 p.m. Diagnoses included, but were not limited to diabetes mellitus, cellulitis (skin infection caused by bacteria) of leg, morbid obesity and hypertension (high blood pressure). A progress note, dated 5/4/12, indicated, "...Oral exam per request. #12 'lost' MOL (molar) filling. Rx (Recommend) office visit for x-ray survey and restorative Tx (Treatment) #12...." The record indicated the restoration was completed on 10/19/2012.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A "Progress Note," dated 08/27/2012 at 7:40 p.m., indicated, "...Client in hall outside of her room yelling, cursing et (and) kicking @ (at) resident (sic) #1063...." A "Progress Note," dated 11/11/12 at 8:30 p.m., indicated, "...Client approached writer @ (at) med (medication) cart for med et (and) accucheck (blood sugar check). C/o (complained of) not seeing well this evening. Asked client what she has had to eat. She states (sic) "Just a sucker." Accu check (blood glucose monitor) 586 (normal non fasting blood sugar is 65-125). Client stated, 'I was shotting (sic) for 700 guess I did not make it.' Snickering...." A care plan initiated in 2008 and titled "Behavior," indicated, "...Res (Resident) will refrain from insulting others/peers/staff daily TNR (until next review) 7/08...." Documentation indicated the care plan had not been reviewed since 07/19/12 and the plan did not address physical aggression. A care plan, initiated 10/24/2007 and titled, "mood" indicated , "...mood disturbances of tearfulness, insomnia, Rep (repeated) health c/o's (concerns)...." The care plan			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated goals for improving mood disturbances and reducing tearfulness. The care plan had not been reviewed, updated since 7/19/12 and did not include method monitoring efficacy of the plan. The quarterly MDS (Minimum Data Set) assessment, dated 09/30/2012, did not indicate dental concerns related to a broken tooth and the record did not include a care plan for dental/oral health. During observations on 11/14/2012 at 10:22 a.m., Resident #2 had a broken tooth in the back of her mouth on the upper left side. During an interview on 11/14/12 at 10:19 a.m., Resident #2 indicated she had a broken tooth and stated, "I need to go to the dentist badly." During an interview on 11/15/12 at 12:53 p.m., Resident #2 stated a tooth on the left upper side of her mouth "is broke (sic) and needs to be fixed." The resident indicated tooth was rough against her tongue. She indicated she informed facility staff of the broken tooth. During an interview on 11/19/2012 at 2:05 p.m., the MDS (Minimum Data			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Set) Coordinator indicated she was not aware Resident #2 had another broken tooth and a care plan for dental/oral health had not been developed. During an interview on 11/15/12 at 2:12 p.m., Resident #2 indicated she had not intentionally tried to elevate her blood sugar. During an interview on 11/19/12 at 1:56 p.m., the MDS Coordinator indicated the MDS indicated the dates listed on the care plan for revision were correct and the plans should have been reviewed quarterly. The MDS Coordinator indicated she was not aware of Resident #2 kicking at another resident and was not aware Resident #2 had made of comment regarding an attempt to elevate her blood sugar to 700. She indicated she had not developed a care plan addressing the behaviors. 7. Resident #98's record was reviewed on 11/16/12 at 2:21 p.m. Diagnoses included, but were not limited to, spinal stenosis, hypertension, congestive heart failure, anemia, and neurogenic bladder. The 14 day MDS, dated 9/6/12,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated, " ...obvious or likely cavity or broken natural teeth ..... " The record did not indicate a care plan for oral/dental health. A progress note, dated 10/19/12 (no time indicated), indicated, "...Oral exam and cleaning...#19 present (symbol for with) occlusal (bite surface of molar) decay. Rx (recommend) office visit for x-ray survey and repair #19...." The 14 day, MDS, dated 09/06/2012, indicated resident was on a scheduled pain medication regimen and received prn (as needed) pain medications. The record indicated a pain frequency of "almost constantly" and indicated a pain score of 8 on a scale of 0-10. A care plan, dated 09/06/2012 indicated approach for pain management was administration of routine/prn (as needed) pain medications. The plan did not include non medication interventions for relieving pain. The MAR (Medication Administration Record), dated November 2012, was reviewed on 11/19/12 at 12:23 p.m. The record indicated Resident #98 received Lyrica 150 mg (milligrams)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	orally twice daily and Percocet 5/325/mg orally every four hours as a scheduled medication for pain management. The record indicated prn (as needed) pain medication had not been requested/given. During an interview on 11/19/2012 at 3:56 p.m., Resident #98 indicated he had a tooth that needed to be filled. During an interview on 11/19/2012 at 2:05 p.m., the MDS (Minimum Data Set) Coordinator indicated pain medications were the only interventions for pain management and indicated resident did not have a care plan for dental/oral health. 8. On 11/13/12 at 2:53 P.M., during the initial tour, Resident #65 was observed in her room with a strong odor of urine. On 11/16/12 at 1:10 P.M., Resident #65's record was reviewed. Diagnosis included, but were not limited to, diabetes mellitus type II, vascular dementia with depression, alcohol abuse, history of urinary tract infection [UTI], and urine retention. A quarterly Minimum Data Set [MDS] assessment, dated 9/14/12, included,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	but was not limited to, toileting required an extensive assist of 1 staff person and the resident was always incontinent of urine. A "Bladder Incontinence Evaluation," dated 3/17/12, included, but was not limited to, "History of incontinence: yes..." A "Genitourinary" care plan, dated 9/6/12 [updated], included, but was not limited to, "Problem: UTI... Goal: asymptomatic... approaches: incontinence protectors..." There was no documentation of a urinary incontinence care plan for the resident. On 11/16/12 at 1:30 P.M., incontinence care was observed for the resident by CNA #27. On 11/19/12 at 9:10 A.M., in an interview, LPN #35 indicated the only care plan for the resident regarding incontinence was the genitourinary care plan. She indicated the only approach related to incontinence was an incontinence protector. The facility was unable to provide a urinary incontinence care plan for Resident #65.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	9. A facility policy and procedure titled "Care Plan," dated 9/01/2011, and received from the Administrator on 11/16/12 at 1:55 p.m., indicated: "Policy: An interdisciplinary plan of care will be established for every resident and updated in accordance with state and federal regulatory requirements and on an as needed basis ...Goals must be measurable and objective. Procedure: The facility must develop a comprehensive Care Plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs ... All staff must be familiar with each resident's Care plan and all approaches ... Care Plans are to be maintained with the current Medical Record ... There must always be back up documentation to show that approaches in the Care Plan are being followed ... All direct care staff must always know, understand and follow their			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN REHABILITATION AND HEALTHCARE CENTER	803 S HAMILTON ST SHERIDAN, IN 46069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident's Care Plan ..." 3.1-35(b)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.			
	Based on interview and record review, the facility failed to ensure nursing staff followed up on a elevated blood sugar for 1 of 11 residents reviewed for unnecessary medications; failed to ensure nursing staff monitored a dialysis shunt access site for 1 of 1 dialysis residents; and failed to comprehensively assess 1 of 4 residents for accidents. [Residents #46, #51 and #2] Findings include: 1. Resident #2's record was reviewed on 11/15/12 at 1:50 p.m. Diagnoses included, but were not limited to diabetes mellitus, cellulitis (skin infection caused by bacteria) of leg, morbid obesity and hypertension (high blood pressure). A "Progress Note," dated 07/18/2012 at 8:00 p.m., indicated, "...Accu (check) HI (high) (blood glucose monitoring with reading that could	F0309	I. Orders for Resident #2 in regards to blood sugar monitoring were reviewed, physician notified and new order obtained for specific blood sugar call parameters and nursing follow up of hyperglycemia. Resident #46 was discharged to home on 12/4/12. Resident #51 was assessed for injury on 11/18/12, physician was notified and orders obtained. Investigation of injury of unknown origin was completed on 11/19/12. LPN #45 and RN #12 were given Employee Coaching Plan - Level I that included education on assessent and documentation of incidents and accidents.II. All residents with IDDM were reviewed by 12/12/12 and orders obtained to ensure specific blood sugar call parameters and nursing follow up of hypeglycemia were in place. No other residents have a dialysis shunt access site. All incidents and accidents were reviewed since survey to ensure that a comprehensive assessment had been completed.III Licensed nurses were inserviced on managment of hyperglycemia,	12/19/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicate a blood sugar greater than 600)...Client states, 'I have ate Donuts, donuts et (and) donuts.' When asked how many, She (sic) states 'More than 6.'...." A "Progress Note," stated 08/15/2012 at 8:00 p.m., indicated "...Client at candy machine. Eating [chocolate candy]. Accu check (blood glucose monitor) 332. A "Progress Note," dated 11/11/12 at 8:30 p.m., indicated, "...Client approached writer @ med (medication) cart for med et (and) accucheck (blood sugar check). C/o (complained of) not seeing well this evening. Asked client what she has had to eat. She states (sic) "Just a sucker." Accu check (blood glucose monitor) 586 (normal non fasting blood sugar is 65-125). Client stated, "I was shotting (sic) for 700 guess I did not make it." Snickering...." The diabetic record was reviewed 11/16/12 at 10:36 a.m. The record indicated blood sugars were monitored 4 times a day(before breakfast, before lunch, before supper, and at bedtime) and insulin coverage was administered per the following sliding scale: 150-199 = 4 units		care ofresident dialysis shunt and assessment of incidents and accidents on 12/10/ 12 and 12/18/12.the Med REc nurse will review all new insulin orders to ensue that specific bllod sugar call parameters and nursing follow up of hyperglycemia are in place. This will be done while completing monthly physcian order re-writes. IV. Licensed nurses, Medical Records Nurse are responsible. The DON/or designee will review/monitor in weekly care meeting. Reviews will be presentedat QAPI monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN REHABILITATION AND HEALTHCARE CENTER	803 S HAMILTON ST SHERIDAN, IN 46069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	200-249 = 8 units 250-299 = 12 units 300-349 = 18 units 350-399 = 24 units 400-449 = 45 units The physician's recapitulation, dated November 2012, indicated, "...CALL ORDERS < (less than) 60/> (more than) 450 GIVE 45 units - DO NOT CALL RESULTS MD (medical doctor) /D/T NON COMP (due to noncompliance)...." The physician orders were reviewed on 11/16/12 at 11:05 a.m. The record did not indicate new orders in response to a blood sugar of 586 on 11/11/2012. During an interview on 11/16/2012 at 10:26 a.m., LPN # 44 indicated Resident #2's blood sugar is checked 4 times daily and treated with a sliding scale for insulin. She indicated Resident #2 was noncompliant with the recommended low concentrated sweets diet. The LPN stated, "[Resident #2 doesn't usually have symptoms of high blood sugar, which is why she is monitored 4 times a day." During a phone interview on 11/16/2012 at 3:55 p.m., LPN #45			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated she notified the physician of Resident #2's elevated blood sugar on 11/11/12 at 8:30 p.m., via fax. She indicated she did not receive a response from the physician in regard to the elevated blood sugar. LPN #45 indicated she administered 45 units of Novolog insulin per standing orders for blood sugars above 450. The LPN indicated Resident #2 went to bed after the insulin was administered. LPN #45 indicated she did not monitor Resident #2's health and did not recheck the resident's blood sugar to verify the blood sugar was at a safe level. During an interview on 11/19/2012 at 10:50 a.m., the DoN (Director of Nursing) indicated the LPN should have rechecked Resident #2's blood sugar after giving the insulin. The DoN indicated she was unaware if there was a facility diabetic protocol, but indicated staff should have monitored the resident after giving the insulin. A policy/protocol for diabetes management was requested, but not provided. 2. The record of Resident #46 was reviewed on 11/16/12 at 10:00 a.m. Diagnoses included, but were not			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	limited to, end stage renal disease, hypertension, congestive heart failure, gastro esophageal reflux disease, and convulsions. An admission Minimum Data Set (M.D.S.) assessment, dated 10/11/12, indicated Resident #46 was mildly cognitively impaired, required extensive assistance for all activities of daily living, was frequently incontinent of urine, and was on hemo dialysis. Physician's admission orders, dated 10/04/12, indicated "L (left) AV (arteriovenous) Fistula Dialysis M-W-F (Monday, Wednesday, Friday". LPN 34 was interviewed on 11/16/12 at 10:40 a.m. She indicated she regularly took care of Resident #46 and was familiar with her condition and care needs including fistula care and dialysis needs. She indicated Resident #46's fistula should be evaluated daily including visual observation of the dressing, checking for signs and symptoms of infection, and checking bruit (the sound of blood pulsing through the fistula) by listening with a stethoscope and thrill (a vibration felt as blood passes through the fistula) by palpating over			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the fistula site Resident #46's nurse's notes were reviewed in their entirety from her admission on 10/04/12 through the time of review on 11/16/12 at 10:00 a.m. Nurses notes indicated the following: 10/05/12 10/06/12, 10/07/12, 10/10/12 contained no mention of the fistula. 10/11/12 " ... no s/s (signs or symptoms) infection ... " 10/11/12 " ...free from bleeding or ss infection ... " 10/12/12 " ...clean no redness or swelling ... " 10/13/12 " ...CDI ... " (clean, dry and intact) 10/14/12 " ...CDI ... " 10/17/12, 10/18/12, 10/19/12 No mention of fistula 10/20/12 " ...CDI no SS infection ... " 10/21/12 " ...CDI no SS infection ... " 10/22/12 " ...CDI no SS infection ... " 10/23/12 " ...CDI no SS infection ... " 10/24/12 No mention of fistula. 10/25/12 " ...CDI ... " 10/27/12 " ...CDI ... " 10/28/12 " ...CDI ... "			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	10/29/12 " ...shunt site CDI bruit & thrill & continue dialysis ... " 11/03/12, 11/04/12, 11/05/12 No mention of fistula. 11/06/12 " ...CDI no problems noted ... " 11/07/12 " ...CDI ... " 11/08/12 " ...CDI no SS infection ... " 11/09/12 " ...CDI no SS infection ... " 11/10/12 " ...CDI no SS infection ... " 11/11/12 " ...CDI no SS infection ... " 11/12/12 " ...CDI no SS infection ... " 11/14/12 " ...CDI ... " 11/15/12 " ...CDI ... " Resident #46's chart contained no other documentation of care or assessment of the fistula, including but not limited to daily assessments for patency, signs and symptoms of infection, aneurysm formation, or vascular insufficiency. 3. A facility policy, dated 10/05, received from the Administrator on 11/16/12 at 1:55 p.m., titled "Care and Maintenance of an Internal Arteriovenous Access Device" indicated: "Purpose: To provide safe and proper care to a resident/patient with an internal arteriovenous (AV) shunt for hemo-dialysis access.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Procedure...Auscultate or gently palpate for pulsation over AV shunt to evaluate patency... Evaluate for signs and symptoms of infection, including , but not limited to: Complaints of pain...Edema...Redness...Tenderness ...Warm to touch... Observe the site for aneurysm formation indicated by abnormal dilation or ballooning out... Evaluate for the following signs of vascular insufficiency as indicated by: Diminished pulses... Ischemic pain distal (away from) to the site of the shunt... Pallor... Document the following to include, but not limited to (sic): Date and time of evaluation... Presence or absence of bruit... Signs and symptoms of infection... Signs and symptoms of aneurysm development... Signs and symptoms of vascular insufficiency... Evaluate resident/patient daily, upon return from dialysis and more frequently, as indicated..."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN REHABILITATION AND HEALTHCARE CENTER	803 S HAMILTON ST SHERIDAN, IN 46069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	4. Observation of Resident #51 on 11/19/12 at 1:05 P.M., was made during shower care. Resident #51 was observed to have a purple bruise on his right thumb near the top of the thumb and around the nail bed. Record Review on 11/19/12 at 2:15 P.M., indicated Resident #51 had diagnoses which included but were not limited to, anemia, hypertension, urinary tract infection, hyperlipidemia, dementia with behavior disturbance, anxiety, depression, stress fx femoral neck, difficulty in walking, muscle weakness, hypothyroidism, hyperlipidemia, leukocytosis, myocardial infarction, insomnia, acetonuria, abnormal glucose, and cardiomegaly. Resident # 51's Minimum Data Set [MDS] assessment quarterly, dated 09/14/12, indicated a BIMS score of "3" which indicated severely cognitively impaired, uses a wheelchair and walker, and needed extensive assist of 1 person with bed mobility, transfers, toileting, hygiene, bathing, and dressing. Review of Physician's Telephone Orders, dated 11/18/12, indicated an order for a x-ray of right thumb/hand			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"(swelling/bruising)" Physician's Telephone Orders, dated 11/19/12, indicated, "Call DR. ____(name of ortho doctor) for ortho f/u [follow up] and tx [treatment] for fx [fracture] L [left] thumb." The clinical record Progress Notes, dated 11/19/12 at 9:40 A.M., indicated "no signs/symptoms of pain or discomfort. (R) [Right] hand edematous." The notes indicated the resident "refused to get up this A.M. for breakfast, but accepted meds without difficulty." Fluids were encouraged and the resident indicated, "I don't want anything, honey. Just leave me alone." Documentation was lacking in regards to information about the incident of the fractured thumb. Radiology Reports, dated 11/18/12, indicated an acute right thumb fracture. Interview with the Assistant Director of Nursing [ADON] on 11/19/12 at 2:40 P.M., indicated she had not completed the investigation on Resident #51's fractured thumb. The ADON indicated she had just started doing interviews and indicated with			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	what she had found out so far, it looked like the nurse was told about his thumb, but forgot to assess and document the incident. An incident report, dated 11/18/12 at 10:30 A.M., described the incident and injury of unknown cause. This report was completed by LPN #11. On 11/19/12 at 2:45 P.M., part of the written investigation documentation was reviewed. It included interviews with staff by the ADON, and indicated CNA #13 heard the alarm go off around 4:30 P.M., on Friday and found the resident on the mat next to his low positioned bed. The interview notes indicated CNA #13 got RN #12 to assist her and RN #12 tried to do vital signs and assessment, but the resident was agitated and refused. CNA #13 and RN #12 assisted the resident to his wheelchair for meal time. RN #12 indicated she would report this to LPN #11. The CNA indicated on Saturday, the resident said "Oh my thumb" during care and noted it to be slightly bruised so she reported it to the nurse. The investigation documentation related to the interview with LPN #11 indicated RN #12 did tell her about the resident being found on the mat			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	on floor and refused assessment, and that she simply forgot to follow up or document on it. In fact, the LPN stated she did not even remember it when she noted the right thumb swelling/bruising on Sunday. She did not remember about it until questioned about it from the ADON. Review of the resident's care plans indicated care plans for the following with the interventions: Fall Risk Identification and Plan of Care/ hx of falls in last 3 months, altered elimination status, diuretics or medications with sedative effects, requires assistance with transferring/ambulating. Interventions: apply star symbol, utilize alarm chair and bed, provide assistance for unsteady gait, initiate starlight program, night light, remind to use call light, bed check q 2 hour, urinalysis, culture and sensitivity, low bed, and left hip xray. Mobility/ Unsteady, sometimes catches self, hx fall backwards, onychomycosis, hx hip left sub cap; Interventions: up with assist, rolling walker, xray right thumb/hand. 3.1-37(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN REHABILITATION AND HEALTHCARE CENTER	803 S HAMILTON ST SHERIDAN, IN 46069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN REHABILITATION AND HEALTHCARE CENTER	803 S HAMILTON ST SHERIDAN, IN 46069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure chemicals were stored out of reach of residents. The deficient practice had the potential to affect 2 of 2 cognitively impaired residents observed near the sani-wipes. [Residents #24 and #71] Findings include: On 11/13/12 at 10:00 A.M., during the initial tour of the facility, Residents #24 and #71 were identified as being cognitively impaired and unable to answer interview questions. On 11/13/12 at 11:55 A.M., a container of "Sani-Wipes" was located on an activity cart near the South unit dining area. At that time, Resident #24 was observed in ambulating in the hallway [in a Merry Walker: mobile walker where residents can stand freely], near the sani-wipes.	F0323	I. The "Sani-Wipes" resident #24 was ambulating near were immediately removed by LPN #21. The "Sani-Wipes" resident #71 was ambulating near were immediately removed by the SSD.II All residents have the potential to be affected. 11/19/12 a facility tour was completed by the ADON to ensure all chemicals were stored out of reach ofresidents.III The Activity Department will no longer use Sani wipes as clean up forpainting. They will use wash cloths. Housekeeping will continue the use of SaniWipes for cleaning of the kiosk, but they are to be locked in carts or closet when not in use. Housekeeping was inserviced on proper storage of chemicals.The Environmental Safety "General Hallway and Dayroom" performance review tool was modified and will be completed weekly x4, then, submitted to QAPI if in compliance then 2x weekly x 4, then x2 monthly, If 100% compliance is reached then quarterly.IV This tool will be presented to QAPI monthly. Maintenance director responsible, Administrator to monitor.	12/19/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 11/13/12 at 12:50 P.M., in an interview, LPN #21 indicated she was not certain if the sani-wipes should be left on the activity cart or not; however, she indicated she would remove the wipes and check and provide the MSDS [Material Safety Data Sheet] for the wipes. On 11/13/12 at 2:15 P.M., LPN #21 provided a MSDS for "DW-Hand Sanitizer Wipes-220 Count Container." The MSDS included, but was not limited to, "Health Hazards: Inhalation: Upper respiratory tract irritation, dizziness may occur... Skin: May cause dermatitis... Ingestion: May present choking hazard for children and pets... Eyes: Emergency and First Aid Procedures: Rinse eyes with large amounts of water, contact physician... Provide oxygen and or ventilation assistance as needed..." On 11/19/12 at 12:15 P.M., a container of "Sani-Wipes" was observed on a table near the South assist dining area. At that time, Resident #71 was observed ambulating around the area.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN REHABILITATION AND HEALTHCARE CENTER	803 S HAMILTON ST SHERIDAN, IN 46069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 11/19/12 at 12:30 P.M., the Social Service Director was made aware of the sani-wipes and removed them from the area. 3.1-45(a)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions			
	Based on observation, interview and record review, the facility failed to keep food covered, have staff use gloves when buttering bread; and failed to maintain 1 of 1 main kitchens in a clean and sanitary condition during 4 of 4 kitchen observations. These practices potentially affected 68 of 68 residents who received meals from the facility kitchen. Findings include: 1. a. During initial tour observations in the kitchen on 11/13/12 between 9:25 a.m. and 10:00 a.m., an undated individual serving size ice cream container was stored in the ice cream freezer. A plastic food container with cooked beef was stored on a shelf above milk in the cooler. Ham, packaged in plastic wrap, was defrosting in the cooler and was stored above a container of food identified by the DM (Dietary Manager) as cooked eggs. A second ham was stored on a container of	F0371	I. 1a Immediately undated food tiems and DA#51's drink was disposed of. I.Dietary staff have been given a desiginated area for their belongings.1b Ceiling vents were replaced 11/14/12. Fans were removed and werecleaned 12/7/12. Speakers in dishroom were removed on 12/10/12.1c All employees will re educated/oreintated on proper food handlin, dating,food storage and laeling. Orienation checklishs will be completed for alldietary employees. Coaching Level I will be reviewed with dietary aid #51 on12/12/12. The handwashing sink fawcett was replaced with conventional bladefawcett. 1d Procedures for soiled dishes has been revised and soiled dishes will enter only thru the dishroom door. Employees re orientated and educated to proper cleaningof dishmachine and walls each shift. All employees will be retrained on proper cleaning of food thermometer.1f A step stool has been provided to visualize the upper shelves of the cooler. Thecooler was sanitized 11/17/12. The area behind the	12/19/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	fluid identified by the DM as broth. A can of soda, identified as belonging to Dietary Aide (DA) # 51 was stored in a cooler with foods to be prepared for residents. Food spillage/residue was present on the lid of a container of cottage cheese. The vegetable cooler contained an undated package of whole carrots, an undated case of lettuce, an undated case of cabbage and 6 additional undated cabbages and one undated bag of broccoli. A bag of pepperoni was stored on top of cheese slices in the vegetable cooler. The meat freezer contained an undated opened box of fish fillets. An undated box of whole potatoes was stored on a bottom shelf in the dry food storage room. A gallon plastic storage bag containing candy sprinkles was stored on the top shelf in the dry food storage room without a date. A table with 3 chairs around it was in the dry food storage area. Coats were hanging on the back of 2 chairs and food residue was present on the table surface. The Dietary Manager was observed throwing away the undated food items at 9:38 a.m. She indicated the food		dishwasher has been repairedand sealent applied. In the air drying area drying mats have been provided. Theemployees break area is out of he food storage room.1g Do-nuts for activities will be individually wrapped. A clean dry cloth will be provided for any spills. A container will be available for the ice scoop.1h Nursing staff will be educated on proper food handling at meal time. Labelswill be purchased for dietary to indicate the "use by" for dating of food items.2. All nursing staff will be educated on proper hand washing and proper food handling. Dietary will cover side dishes with protective wrap.II All residents have the potenial to be affected. There is no indication from our Infection Control monitoring that anyone has been.III. Areas reported as soiled have been cleaned. Equipment that was cited havebeen removed and/or cleaned. Staff nursing as well as Dietary will be re educated to proper procedures of food handling. Specific staff cited have been counseled. Revision to delivery of carts and meals have been made. Employeebreak area is not longer in the dry storage are.IV. Dietary Manager /or Designee will monitor weekly. RD to do monthly audits. Addendum: Administrator/or designee will do mock survey 5x a week, to monitorcleaning, new procedures and handwashing. FSM will monitor daily as part	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	should not be served to the residents. During an interview on 11/19/2012 at 8:27 a.m., the DM stated, "Everything that is put in the refrigerator should be labeled." The DM indicated staff should not have stored personal beverages in the cooler with resident food. b. During initial tour observations in the kitchen on 11/13/12 between 9:25 a.m. and 10:00 a.m., vents near the ceiling above the designated hand washing sink had black speckled residue on the grids and air from the vents blew across the food preparation area. The wall under the vents also had black speckled residue. The light above the hand washing sink had a layer of brownish/black debris at corner of the fixture. A fan was on the floor by the wash sink blowing air into area where food was stored in coolers. The fan had visible dust/lint on the blades. A second fan with lent/debris on the blades and surface blew air across the area where dishes were placed to dry following a dishwashing cycle. The ceiling above the cook area had food splatters and spills were present on the floor in front of the oven. Additional spills were noted on the floor near the hand washing sink in		ofsupervision responsibilities.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the food preparation area. Speakers that had been hung on the wall in the dishwashing area were heavily covered with dust. During an interview on 11/13/12 at 10:12 a.m., the DM indicated all areas of the kitchen were cleaned weekly and deep cleaning had been completed a week prior to the survey. During an interview on 11/19/2012 at 8:27 a.m., The DM indicated the kitchen had not been tested or identified as having mold. The DM indicated the kitchen was deep cleaned once a month. c. During initial tour observations in the kitchen on 11/13/12 between 9:25 a.m. and 10:00 a.m., a partially full (1/4) package and full loaf of bread were stored behind the food prep sink with the plastic bags laying in moisture from the sink. DA #51 handled uncooked chicken without wearing gloves. She used a hot pad to pull a pan of partially baked chicken from the oven. The hot pad touched the meat when the pan was pulled from the oven. DA #51 washed her hands in the designated hand washing sink after handling the chicken with ungloved hands. DA #51 pushed a rod on the sink to allow			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	water to flow from the faucet. The rod was not sanitized after use. A sign posted next to hand washing sink indicated, "Clean sink & rod daily with approved disinfectant, always spray with disinfectant after working with meats and poultry." During an interview on 11/19/2012 at 8:27 a.m., the DM indicated the bar on the hand washing sink should be sanitized weekly. The DM indicated she was not aware there was a sign posted next to the sink instructing sanitizing the bar after contact with hands that touched meat or poultry. d. During a second observation in the kitchen on 11/13/2012 at 10:12 a.m., DA #51 was mashing potatoes while standing next to carts containing room trays returned from the units to the kitchen with residents' dirty breakfast dishes. An apron was observed on floor next to the vegetable cooler. The dishwasher had whitish- colored debris along the edges of unit's door The ED (Executive Director) identified the debris as grease. e. During a third observation in the kitchen on 11/13/2012 between 11:45 a.m. and 12:15 p.m., DA #51 used a towel to wipe a spill from the floor			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	surface in front of the steam/serving table. The towel remained on the floor for the remainder of the observation period. DA #51 checked food temperatures at 11:55 a.m. The thermometer was cleaned by dipping it into a sanitizing solution, then wiping it the probe with a cloth soiled with food residue for 3 observations. DA #51 placed the thermometer probe into mechanical soft chicken to obtain a food temperature. She removed the thermometer, wiped it with the soiled cloth, then placed the thermometer probe in the pureed chicken without sanitizing the thermometer between food items, During an interview on 11/13/12 at 11:55 a.m., DA #53 indicated the procedure for cleaning the thermometer had not been followed because there were no alcohol wipes available for use. She indicated the thermometer was usually cleaned by dipping it in the sanitizer solution, then placing the thermometer in its storage container. She indicated alcohol pads should have been used to wipe the thermometer before using. During an interview on 11/19/2012 at 8:27 a.m., the DM indicated spills should have been wiped from the floor immediately, then mopped later.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	She indicated a towel should not have remained on the floor after the spill was removed. The DM indicated alcohol wipes should have been used for cleaning the thermometer and stated, "I didn't know we were out." f. During a fourth observation in the kitchen on 11/16/2012 at 8:30 a.m., the DM climbed into the vegetable cooler, allowing the soles of her shoes to come in contact with a shelf where food was stored. A box of ground turkey was stored on top of box of bread sticks in meat freezer. A ham and bag of chicken was stored on a shelf above strawberries. A package of crab was stored directly on top of the box of frozen berries. During an interview on 11/19/2012 at 8:27 a.m., the DM indicated meats should not have been stored on top of fruits/vegetables and indicated the meats should have been stores in a separate area of the freezer/cooler than the fruits/vegetables. The DM indicated all residents eat food prepared in the kitchen. Serving utensils were stored in bins in the dish washing area. The area behind the dish washing sink had substances flaking away from the wall's surface. DA #53 scraped the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	wall with her fingernails and identified the chipping as paint. During an interview on 11/18/12 at 8:30 a.m., DA #53 indicated serving utensils and silverware were stored in bins overnight for air drying. She indicated the silverware would be placed in drawers when they were completely dry. DA #53 indicated staff eat lunch and take breaks in the in dry food storage area. g. During observations in the main dining room on 11/13/2012 at 10:00 a.m., two trays of donuts (24 donuts) were stored uncovered on a cart that also contained drinking glasses. A soiled wash cloth was laying next to the drinking glasses, touching the lip of the glasses. A scoop was left in a bucket of ice. h. During dining observations on 11/13/12 between 12:15 p.m. and 12:55 p.m., CNA (Certified Nurse Aide) #42 removed bread from a sandwich bag with ungloved hands and touched the food item before handing it to resident #5 at 12:15 p.m. At 12:30 p.m., CNA #42 touched Resident #32's bread with her ungloved hands. Cake was served uncovered to all residents.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A policy, dated 03/2012 and titled, "Safety Precautions-Food Services, " indicated, "...Do not store dishes, glassware or other articles where food is being prepared...Mop up spills immediately.... A policy, dated 02/2003 and revised 06/2009, titled, "NUTRITION SERVICES MANUAL, " indicated, "...Maintain thermometers in their proper protective cases. Use an alcohol swab before and after each use. Allow to air dry prior to taking next temperature...." A policy, dated 03/2012, and titled, "Food Supply Storage," indicated, "...Food and supplies will be stored under sanitary and secure conditions and according to approved State and Federal standards, to retain quality of products...Opened packages must be dated with a "use by" date of 3 months from the date opened...All commercially packaged foods which require refrigeration after opening must be dated when received and dated a second time when opened...." 2. Observation of a lunch meal time was observed on 11/13/12 at 12:20 p.m., in the 100 hall dining room. The Resident Staff Coordinator was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	observed to be buttering bread for the 3 residents seated at the table. The Resident Staff Coordinator was observed to butter the bread from 1 res. to the next resident with her bare hands. The Resident Staff Coordinator was observed to not wash her hands, used no disinfectant gel between the residents, and used no gloves. Interview with the Dietary Supervisor on 11/19/12 at 5:45 p.m., indicated staff should use the gel between each resident meal set up. Review of the facility's handwashing policy with revised date of 2/09 indicated, "The facility will follow the Center for Disease Control (CDC) Guidelines for handwashing. Handwashing is the single most important procedure for preventing nosocomial infections. The facility requires personnel to wash hand thoroughly to remove dirt, organic material, and transient microorganisms. Handwashing is mandated between resident/patient contact in an effort to prevent the spread of infection..." 3. A lunch time dining observation was made on 11/13/12 and 11/19/12.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 11/13/12 at 11:55 P.M. and 11/19/12 at 12:15 P.M., lunch was served in the South assist dining area. The individual resident trays were brought to the area in a rolling, closed cart. Upon delivery to each resident, the trays were observed without a protective covering over the side dishes. The side dishes included individual drinks, cottage cheese, fruit, desserts, etc. 3.1-21(i)(3)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012

NAME OF PROVIDER OR SUPPLIER: SHERIDAN REHABILITATION AND HEALTHCARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 803 S HAMILTON ST, SHERIDAN, IN 46069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on observation, record review and interview, the facility failed to promptly obtain a dental referral for 1 of 3 residents reviewed for dental services (Resident #2). Findings include: During observations on 11/14/2012 at 10:22 a.m., Resident #2 had a broken tooth in the back of her mouth on the upper left side. Resident #2's record was reviewed on 11/15/12 at 1:50 p.m. Diagnoses included, but were not limited to diabetes mellitus, cellulitis (skin infection caused by bacteria) of leg, morbid obesity and hypertension (high blood pressure). A progress note, dated 5/4/12, indicated, "...Oral exam per request.	F0412	I. On 11/2012 a 12/3/12 appointment was scheduled for Resident #2 for exam and restorative dental treatment. II All residents have the potential be be affected. All residents were either interviewed (using CMS form 20050) or observed (using CMS 20050-a) for the need of dental referral. The last dental progress note was reviewed for every resident on 12/10/12, to insure there were no missed referrals.III The dental provider will have an exit interview at each visit with the Med/Recnurse. In the exit the dentis will provide a current progress not and any further treatment required. The Med/Rec nurse will contact the office to arrange. Allstaff will be inserviced on 12/13 and 12/17/12 regarding dental services.IV. The Med/Rec nurse or designee will interview or observe 5 residents usingCMS20050 N or Section A monthly x 3 months then	12/19/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	#12 'lost' MOL (molar) filling. Rx (Recommend) office visit for x-ray survey and restorative Tx (Treatment) #12...." The record indicated the restoration was completed on 10/19/2012. During an interview on 11/14/12 at 10:19 a.m., Resident #2 indicated she had a broken tooth and stated, "I need to go to the dentist badly." During an interview on 11/15/12 at 12:53 p.m., Resident #2 stated a tooth on left upper side of her mouth "is broke (sic) and needs to be fixed." The resident indicated tooth was rough against her tongue. She indicated she informed facility staff of the broken tooth. During an interview on 11/19/2012 at 2:05 p.m., the MDS (Minimum Data Set) Coordinator indicated she was not aware of the 05/04/2012 dental recommendation until July 2012. She indicated the dentist appointment was completed on 10/19/2012. The MDS Coordinator indicated she was not aware Resident #2 had another broken tooth and a dental appointment had not been scheduled. 3.1-24(a)(3)		quarterly. The PerformanceTool will be completed by Medical Records and submitted monthly to QAPI monthly.Licensed personnel, Dental Service Provider and Medical Records/designee responsible. DON to monitor.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN REHABILITATION AND HEALTHCARE CENTER	803 S HAMILTON ST SHERIDAN, IN 46069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012

NAME OF PROVIDER OR SUPPLIER: SHERIDAN REHABILITATION AND HEALTHCARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 803 S HAMILTON ST, SHERIDAN, IN 46069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation, interview and record review, the facility failed to ensure a flu vaccine was dated with date opened when opened for use,	F0431	I. The vial of vaccine not dated was destroyed on 11/17/12. The refridgerator was defrosted and all non medication items were removed on 11/16/12. Noted	12/19/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and failed ensure that stored refrigerated medications was the only thing refrigerated in the refrigerator for 1 of 2 refrigerators used for medication storage. Findings include: The 200 hall refrigerator was observed on 11/16/12 at 9:35 a.m.. The refrigerator was observed to have an opened vial of flu vaccine with no label of the date in which it was opened. The expiration date on the vial of vaccine was 5/13. The refrigerator was also observed to have 2 dark Hershey candy bars and 2 bottles of chocolate syrup refrigerated. The refrigerator was observed to be in need of defrosting as ice build up was found in the freezer compartment and down the back of the refrigerator. Observed on the floor of the medication room was a box of medications which included 1 large bottle of Complete Ultra Women's Health, 1 bottle of Uloric 40 mg medication, 1 box of Cholestyramine which held 62 packets in the opened box, and Levothoxine 75 mcg.- 1 pop out sheet. LPN #15 explained these were medications that needed to be scanned and returned to the		Medications were returned to the pharmacy on 11/17/12.II All residents could be affected. The medication room for the 100 hall was checked on 11/16/12 to ensure all items were dated when opened and only medications were present in the fridge. All medications requiring return were processed.III. The fridge for 200 was relocated to a lower surface to nsure clear visualization of the entire contents. Licensed nurses were inserviced on 12/12/ and 12/17/12 on proper labeling and distruction. Weekly medication return and weekly medication fridge clean was assigned to a specific nurse. Survey of theMedication Room/Cart Inspection Report will be conducted weekly assigned.Omnicare Pharmacy Tech will complete monthly quality assurance inspectionand report.The ADON or designee will complee he medication room-card performance improvement tool monthly x3 then quarterly.IV Licensed Nurses, Pharmacy Tech and ADON/ Designee responsible.DON to monitor. QAPI will review monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	pharmacy. LPN #15 indicated this process is usually done on night shift and she did not know how long the medications had been sitting there. Review of the facility's policy on "Packaging and Labeling" with revised date of 11/03/06, indicated, "Medications are packaged and labeled in accordance with facility requirements and state and federal laws. ...Small multidoses vials such as insulin, eye drops, ear drops, etc. are dispensed in amber packaging vials. The pharmacy label and any appropriate ancillary labels (ie precautionary and date opened stickers) are placed on the packing vial to prevent covering important information on the medication vial...." Review of the facility's policy on Storage of Medication with revised date of 12/01/06 indicated, "... Food is not stored in the refrigerator, freezer, or general storage areas where drugs and biologicals are stored...." 3.1-25(j)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to	F0441	I. LPN was given an employee Coaching Plan Level I that	12/19/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	ensure kitchen staff performed effective handwashing techniques; and failed to ensure nursing staff utilized gloves while performing a glucometer test. In addition, the facility failed properly store a resident's nebulizer tubing [Resident #82]. Findings include: 1. On 11/15/12 at 3:17 p.m., observation of LPN #16 was made of Resident #14's blood glucose testing. LPN #16 was observed to take Resident #14's blood sugar using her glucometer. LPN #16 was observed to clean the resident's finger with an alcohol swab and prick her finger with a lancet. LPN #16 gathered the blood onto the reagent strip. Resident #14's blood sugar reading was 322. LPN #16 was observed to wear no gloves during this procedure. Interview with LPN #16 after leaving the resident's room indicated he should have worn gloves. Review of the facility's policy on Blood Glucose Monitoring with last review date of 09/01/12 indicated, "... Procedure ... Wash hands ... Put on gloves...."		included education onutilization of gloves when performing a glucometer test with all residents. Upon discovery of low water temps in handwashing sink, the Mainenance Director adjusted the temp and water was up to temp in 10 mins. With regard to the Neb tubing, a small stand was obtained for resident #82 and was placed by the bathroom door per her instruction. The neb and tubing was placed in an appropriate container.II All residents receiving glucometer testing are at risk. LPN # 16 was givne an employee coaching plan Level 1, that included the use of gloves for glucometer checks. All residents could be affected by low temps in the handwashing sinkReview of Infectiion control logs indicated ther was no outcome. All residents with neb treatments on 11/19/12 was checked to ensure proper storage of administration set storage.III All nurses were inservied on 12/10 and 12/18/12 on gluclose monitoring including the use of gloves. The Mainenance Diector replaced the water fawcet set on 11/20.Dietary staff was inserviced on 12/12/12 in regard to Retail Fod Establishment Sanitation Requiements as related to water temp and handwashing.Interview wiwth resident #82 revealed she frequently removes nebulizer administration set indepentdently from supply bag and does not always remember to put it	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. During an observation on 11/13/2012 at 9:15 a.m., the water in the designated hand washing sink in the food preparation area of the kitchen was cold. The water temperature did not increase to a warm temperature when the water was left running for 1 minute. During observations on 11/13/12 between 9:15 a.m. and 10:00 a.m., Dietary Aide #51 washed her hands in the designated hand washing sink in the food preparation area two times.		back.She agreed to a visual reminder on her stand to help her remember.IV The Special Procedure Performance Review Tool in regards to blood glucose monitoring, including infection control measures will be completed by the DON ordesignee on 3 residents monthly x 3 months, then quarterly. Maintenace will complete a check for temps in the hand sink 5x / 2 weeks then 2 x / weekly/ for 1 month, then then weekly. Nursing and Dietary staff are responsible for their areas. DON, Maintence Director to monitor and report to QAPI monthly.Addendum: the hand sink in the kitchen has been added to the daily temp sheetcompleted on TELS. Maintenance will maintain temps and record.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an observation on 11/13/2012 at 11:45 a.m., Dietary Aide #52 washed his hands in the designated hand washing area of the food preparation area of the kitchen. A water temperature was checked by the Maintenance Director immediately after Dietary Aide #52 washed his hands. The Maintenance Director indicated the water temperature was 68 degrees. He adjusted the water temperature and rechecked the temperature at 11:55 a.m. The water temperature was 105.4 degrees. The "Retail Food Establishment Sanitation Requirements," effective November 12, 2004, indicated, "...Food employees shall...clean their hands and exposed portions of their arms...for at least twenty (20) seconds in water having a temperature of at least one hundred (100) degrees Fahrenheit...." During an interview on 11/19/2012 at 8:27 a.m., the Dietary Manager indicated the water in the hand washing sink should have been warm when Dietary Aides # 51 and 52 washed their hands for effective hand sanitation. 3. On 11/13/12 at 9:30 A.M., during the initial tour of the facility, Resident			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN REHABILITATION AND HEALTHCARE CENTER	803 S HAMILTON ST SHERIDAN, IN 46069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	#82's room was observed. At that time, a nebulizer machine with tubing was observed on a chair near the restroom door without a bag or protective covering noted around the tubing. The tubing had residue. No one was observed in the room at that time. On 11/1412 at 10:00 A.M., Resident #82's room was observed. At that time, a nebulizer machine with tubing, was observed on a chair, located near the restroom door. No protective bag or covering was observed around the tubing. Resident #82 was observed in her wheelchair. 3.1-18(b)(1) 3.1-19(f)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN REHABILITATION AND HEALTHCARE CENTER	803 S HAMILTON ST SHERIDAN, IN 46069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to maintain clean and sanitary restrooms in 4 of 40 resident restrooms observed. [Rooms 111, 205, 210 and 216] Findings include: On 11/13/12 at 9:30 A.M., during initial tour of the facility, 4 of 40 resident restrooms [Rooms 111, 205, 210, and 216] were unclean, had strong odors of urine, and chipped flooring. During observation on 11/19/12 at 3:20 P.M., the restrooms remained with strong odors of urine. On 11/19/12 at 3:00 P.M., the Environmental Services Supervisor indicated residents tend to urinate on the floor and some bathrooms require more frequent cleaning. She indicated those bathroom floors required more scrubbing to remove the yellow stains. On 11/19/12 at 3:40 P.M., the	F0465	I. Immediately the floor and toilets were cleaned.II All residents could be affected by this. All bathrooms will be inspected by the Maintenance and Housekeeping Supv for chipped floors, strong oders and toilet function. Cleaning and/or replacement will be scheduled.III. The frequent bathroom cleaning list will be completed by the housekeepersdaily and dated. It will be reviewed by the Supervisor weekly, with a copy tothe Administrator.IV Housekeepers, Supervisor responsible.Administrator to monitor	12/19/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN REHABILITATION AND HEALTHCARE CENTER	803 S HAMILTON ST SHERIDAN, IN 46069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Environmental Services Supervisor provided a list of "Bathrooms to check more then once a day," no date documented. The list included 11 restrooms that required more than once a day cleaning. 3.1-19(f)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on interview and record review, the facility failed to identify non-compliance related to the development of Care Plan entries and interventions for current issues, and a repeat non-compliance related to kitchen sanitation, through the quality assurance protocol. Findings include: In an interview on 11/19/12 at 10:30	F0520	I. The care plan for resident #4 addressing pain/discomfort was reviewed on 12/10/12 non pharmacological approaches. The care plan addressing vision for resident #50 was reviewed on 12/10/12 and updated to include all vision issues and interventions to assist with her current vision issues. The care plan for #80 adessingpsychotropic medications was reviewed on 12/11/12 and updated to include side effect and efficacy monitoring. A care plan was	12/19/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A.M., the Executive Director indicated the facility's Quality Assurance committee met every month, and chose specific topics to be discussed at each meeting. She indicated the committee might select a focus committee to look at specific issues that may have come up. The committee used threshold limits, and anything that was under their designated threshold would have further assessments done, looking for a root cause. In addition to the monthly meeting, specific staff met every day to try to "keep things from getting out of control." Nursing progress notes were reviewed daily. Topics available to be covered monthly included, but were not limited to, infection control, meal service, nursing medical practice, nutritional care, quality of life, environmental safety, and infection control, activities, hydration, restraints, pressure sores, problem resolution, range of motion, sanitation/food safety, resident funds, vision and hearing, food temperatures, laundry, maintenance and storage. In addition, the facility did a "Mock survey" daily, looking at grooming,		developed for resident #95 addressing he change in discharge destination. Resident #46 was discharged to home on 12/4/12. REsidents #2's entire care plan was updated on 12/ll/12 The care plan addressing behaviors was update to include phycical agression and dietary non compliance. The care plan addressing mood was updated to include efficacy monitoring. The care plan addressing dental services was updated with current dental needs. The care plan for #98 addressing pain was updated to include non pharmcological approach and a dental/oral health care plan was developed. A caer plan was developed for resident #65 addressing urinary incontinence. The resident profile for each resident was updated as indicated.II All residents have the potential to be affected. The Performance Improvement Quailty Assurance policy and procedure will be presented to all members of the committee again for the purpose of education and procedure review.III A review of the assignments will be done by the Administrator with in put from the Regional Clincal Specialist. IV QAPI committee members responsible, Administrator and RCS will monitor monthly for effectiveness and completeleness for 3 months then quarter.Addendum: Each committee member is responsible for their portion of QA/QI.The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	call lights placed correctly, meal trays timely, dignity/knocking, knowledge about falls, positioning, incontinence care, water pitchers, transport, dating O2 tubing, elopements, medication carts locked, missing items, nourishment room, and refrigerators. Corrective action reports were issued following the evaluation of the information gathered. During the Recertification Survey process from 11/13/12 to 11/19/12, resident record reviews, observations and interviews indicated 8 of 40 residents reviewed for Care Plan development and interventions lacked either a Care Plan entry addressing the issue, or lacked specific interventions to be provided by the facility for an identified problem area. Residents #4 and #98 lacked non-medication interventions for pain issues; Resident #50 lacked interventions for vision problems; Resident #80 lacked interventions for psychotropic medications; Resident #95 lacked interventions related to discharge planning; Resident #46 lacked interventions related to a dialysis shunt access site; Resident #2 lacked interventions related to behavior problems; and Resident #65 lacked a Care Plan addressing an		administrator or designee will review QA tools to insure observation and dataare trending with our daily mock survey reports. An identified improvement areawill be added to the Performance Improvement Form and reviewed monthly untilthreshold has been reached for 3 months consistently.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	incontinence issue. In the interview on 11/19/12 at 10:30 A.M., the Executive Director indicated the Quality Assurance protocol for reviewing Care Plans came under the "Nursing Medical Practice/Medical Record" topic. All staff were to review Care Plans for completeness, with the MDS Coordinator as director. The Executive Director indicated the MDS was reviewed on admit, annually, quarterly, and with a significant change of condition. Care Plans were checked to make sure the stated "Problem" reflected the issue and was complete and clearly stated. She indicated the facility threshold was 100%, with six Care Plans reviewed per week. In an interview at that time, the ADON [Assistant Director of Nursing] indicated that the six Care Plans were reviewed only annually. The Executive Director agreed that this was so. The Executive Director indicated the Quality Assurance committee also looked at repeat citations of deficiencies, looking at the actual findings cited. She indicated that during the last annual survey, the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	facility was cited for dirty meat slicer. The meat slicer was now being monitored daily. Observations of the facility kitchen and dining rooms on 11/13/12 and 11/16/12, indicated food items were found to be stored without labels or dates; were not stored in a manner to prevent contamination of other foods; kitchen walls, floors, and air vent grills had spills, dirt, debris, and an unidentified black substance; there was improper food handling and hand washing techniques, and improper sanitation of equipment; and there was improper handling of food items in the dining rooms. There was no indication the full extent of the Federal regulation related to kitchen sanitation was included for the Quality Assurance committee to monitor. On 11/19/12 at 11:45 A.M., the Executive Director provided the facility's policy/procedure titled "Performance Improvement (Quality Assurance)" and dated 03/12. The policy/procedure included, but was not limited to, the following information: "POLICY: LaVie Care Centers will			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	have an ongoing performance improvement program designed to systematically monitor and evaluate the quality and appropriateness of Resident care, pursue opportunities to improve resident care, resolve identified problems and identify goals of LaVie Care Center and examines both outcomes and processes relevant to these outcomes with the objective of improving the organization's performance. PROCEDURE: ... 4. Review activities will include but not be limited to: Infection control; ... Interdisciplinary care planning; ... environment of care/safety... 13. The Performance Improvement Program will be evaluated annually by the Performance Improvement Committee to assess that the Program's activities have achieved substantial performance improvement...." 3.1-52(b)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN REHABILITATION AND HEALTHCARE CENTER	803 S HAMILTON ST SHERIDAN, IN 46069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	STATE FINDINGS 3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS 1. (r) Hot water temperature for all bathing and hand washing facilities shall be be controlled by automatic control valves. Water temperature at point of use must be maintained between one hundred degrees Fahrenheit (100 degrees F) and one hundred twenty degrees Fahrenheit (120 degrees F). This State Rule was not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure 1 of 2 designated hand washing sinks in the kitchen operated with warm water. Findings include: During an observation on 11/13/2012 at 9:15 a.m., the water in the designated hand washing sink in the food preparation area of the kitchen was cold. The water temperature did not increase to a warm temperature when the water was left running for 1	F9999	I. Immediately the maintenance Dir brought the temp up to standard. in 1 mins.II All residents have the potential to be affected. A review of infection cotnrol logs indicated no one was affected.III. The entire fawcet was replaced which will allow better control of temerpaturesIV The maintenance director will increase water temp checks to 5x a week for 2 weeks, then 2 times a week for 2 months, then quarterly.	12/19/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	minute. During observations on 11/13/12 between 9:15 a.m. and 10:00 a.m., Dietary Aide #51 washed her hands in the designated hand washing sink in the food preparation area two times. During an observation on 11/13/2012 at 11:45 a.m., Dietary Aide #52 washed his hands in the designated hand washing area of the food preparation area of the kitchen. A water temperature was checked by the Maintenance Director immediately after Dietary Aide #52 washed his hands. The Maintenance Director indicated the water temperature was 68 degrees. He adjusted the water temperature and rechecked the temperature at 11:55 a.m. The water temperature was 105.4 degrees. The "Retail Food Establishment Sanitation Requirements," effective November 12, 2004, indicated, "...Food employees shall...clean their hands and exposed portions of their arms...for at least twenty (20) seconds in water having a temperature of at least one hundred (100) degrees Fahrenheit...." During an interview on 11/19/2012 at			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN REHABILITATION AND HEALTHCARE CENTER	803 S HAMILTON ST SHERIDAN, IN 46069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	8:27 a.m., the Dietary Manager indicated the water in the hand washing sink should have been warm when Dietary Aides # 51 and 52 washed their hands for effective hand sanitation. 3.1-19(r)			