

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  09/30/2014
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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00155737.</p> <p>Complaint IN00155737 - Substantiated - Federal deficiencies related to the allegations are cited at F 164, F 241, F 242, F 246, F 312, F 315, F 353.</p> <p>This visit resulted in an Extended Survey-Immediate Jeopardy</p> <p>Survey dates: September 22, 23, 24, 25, 26, 29 and 30, 2014. Extended survey dates: September 25, 29, and 30, 2014.</p> <p>Facility number: 000336 Provider number: 155376 AIM number: 100290170</p> <p>Survey team: Gloria Bond, R.N., Team Coordinator Tammy Alley, R.N. (9/22, 24, 25, 26,29, and 9/30/2014) Michelle Hosteter, R.N. Sandra Nolder, R.N.</p> <p>Census bed type: SNF/NF: 71 Total: 71</p>	F000000		

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

TITLE

(X6) DATE

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

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F000157 SS=D	<p>Census payor type Medicare: 6 Medicaid: 46 Other: 19 Total: 71</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by Debora Barth, RN.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p>						

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	<p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview the facility failed to ensure the physician was contacted timely for follow-up for 1 of 1 resident reviewed for physician notification in a sample of 35. (Resident # 77).</p> <p>Findings include:</p> <p>The record for Resident # 77 was reviewed on 9/26/14 at 3:04 P.M. Current diagnoses included, but were not limited to, anemia.</p> <p>Nursing notes, dated 8/15/14, indicated the resident went to the Emergency Room and returned with on order for an antibiotic for a Urinary Tract Infection (UTI).</p> <p>Physician orders indicated: 9/3/14: UA C&amp;S (Urinalysis with Culture and Sensitivity)</p>	F000157	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations.</p> <p>F-157</p> <ol style="list-style-type: none"> <li>Resident # 77 no longer resides in the facility.</li> <li>All residents have the potential to be affected by this alleged deficient practice. The Director of Clinical Services (DCS)/Nurse Manager will review laboratory tests ordered during the month of October for physician notification by October 24, 2014. Any issues identified will be corrected immediately.</li> <li>On 10/09/14 the DCS re-educate the licensed</li> </ol>	10/30/2014

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	<p>9/10/14: Macrobid 100 mg (milligrams) every 12 hours for 7 days</p> <p>A Urinalysis, dated 9/6/14, indicated the resident had 2+ leukocytes (abnormal), few bacteria (abnormal) and had enterococcus faecalis (bacteria causing infection) in her urine with a culture and sensitivity completed. The lab indicated the physician was faxed the lab on 9/6/14. The lab was signed on 9/10/14 by the physician.</p> <p>A hospital physician history and physical, dated 9/22/14, indicated the resident was admitted to the hospital for sepsis secondary to a UTI.</p> <p>During an interview on 09/29/2014 at 10:20 A.M., additional information was requested from the DCS (Director of Clinical Services) related to the delay in physician response to the UA results.</p> <p>During an interview with the DCS on 09/29/2014 at 12:38 P.M., he indicated he had no additional information to provide related to the lack of timeliness of physician response to the UA results.</p> <p>A Policy titled "Change in Resident Condition" was provided by the DCS on 9/29/14 at 1:15 P.M., and deemed as current. The policy indicated:</p>		<p>nurses on physician notification emphasis was placed on reporting lab results.</p> <p>4. The DCS/Nurse Manager will conduct Quality Improvement (QI) monitoring of the regulation F157 to ensure the physician is contacted timely. QI monitoring will be conducted five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months using a sample size of five residents. The DCS/Nurse Manager will report findings to two quarterly Quality Assurance Performance Improvement (QAPI) committee meetings. The QAPI committee consisting of the Executive Director (ED), the Director of Clinical Services (DCS), the Medical Director, and 3 other staff members will determine if further action needs to be taken and determine the continued time schedule for further monitoring,</p>		

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F000164 SS=D	<p>"...Procedure...2. The Physician...will be notified as soon as possible include but not limited to significant change...change in treatment...All physician-ordered interventions will be immediately carried out by the Clinical Nurse...."</p> <p>3.1-5(a)(2)</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's</p>			

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	<p>records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation and interview, the facility failed to provide privacy during peri care to a resident for 1 of 1 residents reviewed for dignity in a sample of 35. (Residents #34).</p> <p>Findings include:</p> <p>1. On 9/22/14 at 1:15 p.m., the door was knocked on before entering Resident #34's room, and a response of "come in" was heard. The resident was observed from the hallway door to be naked from the waist down. There were two unidentified CNA's in the room providing care to the resident. The privacy curtain was not pulled by the entrance of the hallway door so when the door was opened, there was potential for any one walking by in the hallway to observe the resident naked as well.</p> <p>On 9/22/14 at 1:45 p.m., Resident #34 indicated she was not comfortable with her body being exposed to people walking by in the hallway.</p> <p>On 9/26/14 at 1:30 p.m., the Director of Clinical Services indicated when someone knocked on a door when care</p>	F000164	<p>1. Resident # 34 shows no apparent adverse affect from this alleged deficient practice.</p> <p>2. All residents have the potential to be affected by this alleged deficient practice.</p> <p>3. The DCS/Nurse Manager will re-educate the nursing staff on providing resident privacy during peri care by October 28, 2014.</p> <p>4. The DCS/Nurse Manager will conduct QI monitoring of the regulation F164 to ensure resident privacy is provided during peri care. QI monitoring will be conducted five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months using a sample size of five random residents. The DCS/Nurse Manager will report findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the</p>	10/30/2014

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F000167 SS=C	<p>was being provided, CNA's should be sure the curtain was pulled, and keep the resident covered before telling any one to come in.</p> <p>This Federal Tag relates to Complaint IN00155737</p> <p>3.1-3(p)(4)</p> <p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>Based on observation and interview, the facility failed to ensure the survey book was readily accessible to residents, families and visitors and failed to ensure the availability signage of the survey book was posted in a visible place. This deficit practice had the potential to impact 71 of 71 residents residing in the facility.</p>	F000167	<p>continued time schedule for further monitoring,</p> <p>5. Date of Compliance: October 30, 2014</p> <p>1. No resident was identified.</p> <p>2. All residents have the potential to be affected by this alleged deficient practice.</p> <p>3. The Regional Director of Clinical Services (RDCS) will re-educate the Department Managers on the regulation F-167 by October 24, 2014. A sign is posted at the front of the facility which</p>	10/30/2014			

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	<p>Findings include:</p> <p>During the initial tour of the facility on 9/22/14 at 9:35 A.M., the survey book and the survey book location signage could not be found.</p> <p>On 9/23/14 at 1:15 P.M., the survey book and the survey book location signage could not be found.</p> <p>During an interview on 9/23/14 at 2:10 P.M., Resident D indicated she knew about the survey book, but she had no idea where it was located in the facility.</p> <p>On 9/24/14 at 10:00 A.M., the survey book and the survey book location signage could not be found.</p> <p>During an interview on 9/24/14 at 3:15 P.M., the Administrator indicated he did not know where the survey book or the sign for the survey book was located. The Medical Records staff person indicated the survey book usually was located on the table in front of the Administrator's office, but she did not see it there today. The Medical Records staff person indicated the survey book had been missing for awhile. The Assistant Business Office Manager indicated there was a laminated sign that indicated where to find the survey book and it had been</p>		<p>includes the location of the survey binder. The survey book will be readily accessible to residents, families and visitors on a table at the front of the facility.</p> <p>The Executive Director (ED)/ Business of Manager (BOM) will conduct QI monitoring of regulation F167 to ensure the survey book is readily accessible to residents, families, and visitors and ensure the availability signage of the survey book is posted in a visible place. The QI monitoring will be conducted weekly for three months and then monthly for three months. The ED/BOM will report findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring</p>		

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F000225 SS=D	<p>posted above the table in front of the Administrator's office, but she did not know what happened to the sign. The Administrator indicated he was told the survey book was located at one of the nurses's stations.</p> <p>At that time the Administrator went to the North end Nurse's station to look for the survey book and indicated he did not find it. He went to the South end Nurses's station and indicated he found the survey book at that station. The Administrator placed the survey book on the table in front of his office.</p> <p>3.1-3(b)(1)</p> <p>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.</p> <p>The facility must ensure that all alleged</p>			

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	<p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>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.</p> <p>Based on record review and interview, the facility failed to ensure an alleged instance of verbal abuse was timely reported, investigated and reported to the Indiana State Department of Health for 1 of 3 alleged instances of verbal abuse. (Resident #56, #36, #14, #24, D, and #67).</p> <p>Finding include:</p> <p>The record for Resident #56 was reviewed on 9/29/14 at 12:15 P.M.. Current diagnoses included, but were not limited to traumatic brain injury, anoxic</p>	F000225	<p>1. Resident # 56 no longer resides at the facility. Residents # 36, 14, 24, D and 67 show no apparent adverse affect from this alleged deficient practice.</p> <p>2. All residents have the potential to be affected by this alleged deficient practice. On 9/25/2014, current residents with a BIMS score greater than or equal to 8 were interviewed and asked:</p> <p>a. Has anyone mistreated you since you have been a</p>	10/30/2014

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	<p>brain injury, dementia with behavior disturbances, affective personality disorder.</p> <p>The, "Interdisciplinary progress notes &amp; comments," indicated Resident #56 had several confrontations with other residents on 9/7/14. It indicated Resident #56 verbally threatened Resident #36 with, "I will kill you." Then she verbally threatened Resident #14, "she was going to kick her a-s." The resident also verbally threatened Resident #24 by indicating, " I f---ing hate you, you should die..." Then the notes indicated, Resident D reported that Resident #56 wanted to, "kill them...", then, " in dining room ... [Resident #67] stated he would be leaving resident [#56] misunderstood and started yelling the F---- word..." The notes indicated the nurse, "...spoke with [symbol for with] resident one on one, told her she shouldn't be yelling at others and cursing because its[sic] not acceptable...."</p> <p>Social Service notes indicated: "9/8/14--spoke with resident about statements made to residents and resident stated 'I would not hurt them. I don't like it here.'" Social Service Designee (SSD) indicated she would try to find another placement for the resident.</p>		<p>resident here?</p> <p>b. Has anyone threatened you since you have been a resident here?</p> <p>c. Are you fearful of anyone here?</p> <p>Any negative responses were further investigated by the ED/DCS/ADCS/ Social Services Director.</p> <p>Residents with a BIMS score less than 8 were assessed by licensed nurses via skin sweeps for suspicious injuries on 9-25-14 and no suspicious injuries were noted.</p> <p>3. On 9-25-14, the Regional Director of Clinical Services re-educated the Interdisciplinary team (IDT) including the ED, DCS, SSD, Activities Director, Assistant Director of Clinical Services (ADCS) and Minimum Data Set (MDS) Coordinator on Abuse Reporting and the Investigation Process.</p> <p>On 9-25-14, the RDCS re- educated the ED, DCS, ADCS and SSD that the facility is to report any allegations of abuse resulting from behaviors to the State of Indiana within 24 hours to be followed by a 5 day investigative summary, accordingly.</p> <p>On 9-25-14, the DCS/ADCS initiated education for facility staff to intervene and report behaviors to</p>	

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	<p>On 9/30/2014 at 9:26 A.M., during an interview with the Administrator, he indicated he became aware of the 9/7/14 event on the following Monday 9/8/14. He indicated he had spoken to Resident #56 on the Monday following the event and she had indicated she was just upset about being in the facility. He indicated he had spoken to Resident #56's room mate (Resident # 24) and she was not fearful and Resident # 56 had been moved out of her room. He indicated there was a grievance form for the event and he would provide the follow-up.</p> <p>On 9/30/14 at 10:30 A.M., during an interview, the Administrator indicated he had not filled out the grievance form, had not been informed of the 9/7/14 event timely, had not investigated the 9/7/14 event and had not reported the event to the Indiana State Department of Health.</p> <p>A policy titled "Resident Abuse" was provided by the DCS (Director of Clinical Services) on 9/24/14 at 11:20 A.M., and deemed as current. The policy indicated: "...Verbal Abuse...Any use of oral, written or gestured language that includes cursing, disparaging and derogatory terms to other residents....All incidents of resident abuse are to be reported immediately to the Clinical Nurse in Charge, Director of Clinical</p>		<p>their supervisor for documentation in the medical record, behavior monitoring sheet and 24 hour report, along with updating of the care plan and any required follow up by the IDT-to include but not be limited to reporting to the State of Indiana within 24 hours and completing a 5 day investigation.</p> <p>4. The ED/DCS will conduct QI monitoring of regulation F 225 by conducting interviews with interviewable residents and staff to determine if any instances of abuse and/or neglect have occurred and need to be reported to the Indiana State Department of Health (ISDH). QI monitoring will be conducted weekly for eight weeks then monthly for four months using a sample size of 5 interviewable residents and 5 staff members. The findings will be brought to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring.</p>		

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069			
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F000226 SS=D	<p>Services, and the Executive Director....The abuse coordinator is responsible for reporting to appropriate officials in accordance with Federal and State Regulations....The abuse coordinator...shall investigate all reports of suspected abuse...shall take statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged abuse...."</p> <p>3.1-28(c) 3.1-28(d) 3.1-28(e)</p> <p>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 record review and interview, the facility failed to timely implement procedures prohibiting the verbal abuse of residents. (Resident #56, #36, #14, #24, D, and #67).</p> <p>Finding include:  The, "Interdisciplinary progress notes &amp; comments," indicated Resident #56 had several confrontations with other residents on 9/7/14. It indicated Resident</p>	F000226	<p>1. Resident # 56 no longer resides at the facility. Residents # 36, 14, 24, D and 67 show no apparent adverse affect from this alleged deficient practice.</p> <p>2. All residents have the potential to be affected by this alleged deficient practice. On 9/25/2014, current</p>	10/30/2014			

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  09/30/2014
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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>#56 verbally threatened Resident #36 with, "I will kill you." Then she verbally threatened Resident #14, "she was going to kick her a-s." The resident also verbally threatened Resident #24 by indicating, " I f--ing hate you, you should die..." Then the notes indicated Resident D reported that Resident #56 wants to, "kill them...", then, " in dining room ... [Resident #67] stated he would be leaving resident [#56] misunderstood and started yelling the F---- word..." The notes indicated the nurse, "...spoke with [symbol for with] resident one on one, told her she shouldn't be yelling at others and cursing because its[sic] not acceptable...."</p> <p>On 9/30/14 at 10:30 A.M., during an interview, the Administrator indicated he had not filled out the grievance form, had not been informed of the 9/7/14 event timely, had not investigated the 9/7/14 event and had not reported the event to the Indiana State Department of Health.</p> <p>A policy titled "Resident Abuse" was provided by the DCS (Director of Clinical Services) on 9/24/14 at 11:20 A.M., and deemed as current. The policy indicated: "...Verbal Abuse...Any use of oral, written or gestured language that includes cursing, disparaging and derogatory terms to other residents....All</p>		<p>residents with a BIMS score greater than or equal to 8 were interviewed and asked:</p> <ol style="list-style-type: none"> <li>Has anyone mistreated you since you have been a resident here?</li> <li>Has anyone threatened you since you have been a resident here?</li> <li>Are you fearful of anyone here?</li> </ol> <p>Any negative responses were further investigated by the ED/DCS/ADCS/ Social Services Director.</p> <p>Residents with a BIMS score less than 8 were assessed by licensed nurses via skin sweeps for suspicious injuries on 9-25-14 and no suspicious injuries were noted.</p> <p>3. On 9-25-14, the RDSC re-educated the Interdisciplinary team (IDT) including the ED, DCS, SSD, Activities Director, Assistant Director of Clinical Services (ADCS) and Minimum Data Set (MDS) Coordinator on Abuse Reporting and the Investigation Process.</p> <p>On 9-25-14, the RDSC re- educated the ED, DCS, ADCS and SSD that the facility is to report any allegations of abuse resulting from behaviors to the State of Indiana within 24 hours</p>	

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	incidents of resident abuse are to be reported immediately...."  3.1-28(a)		to be followed by a 5 day investigative summary, accordingly. On 9-25-14, the DCS/ADCS initiated education for facility staff to intervene and report behaviors to their supervisor for documentation in the medical record, behavior monitoring sheet and 24 hour report, along with updating of the care plan and any required follow up by the IDT-to include but not be limited to reporting to the State of Indiana within 24 hours and completing a 5 day investigation.  4. The ED/DCS will conduct QI monitoring of regulation F 226 by conducting interviews with interviewable residents and staff to determine if any instances of abuse and/or neglect have occurred and need to be reported to the Indiana State Department of Health (ISDH). QI monitoring will be conducted weekly for eight weeks then monthly for four months using a sample size of 5 interviewable residents and 5 staff members. The findings will be brought to two quarterly QAPI committee meetings. The QAPI committee will determine if further action	

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</p> <p>Based on observation and interview, the facility failed to provide an assistive device to a resident as requested. (Residents #36).</p> <p>Findings include:</p> <p>Resident #36's record was reviewed on 9/29/14 at 5:27 P.M. Diagnoses included, but were not limited to, multiple sclerosis, intervertebral disc disease, disc degeneration and low back pain.</p> <p>The Annual Minimum Data Set (MDS) assessment, dated 6/30/14, indicated the resident required the following: Transfers-Supervision/Setup help Walk in room/corridor-Supervision/Setup help Locomotion on/off</p>	F000241	<p>F-241</p> <p>1. The assistive device was located and Resident # 36 shows no apparent adverse affect from this alleged deficient practice.</p> <p>2. Residents utilizing an assistive device have the potential to be affected by this alleged deficient practice.</p> <p>3. The DCS/Nurse Manager will re-educate Licensed Practical Nurse (LPN) #6 on providing assistive devices when residents request by October 28, 2014.</p> <p>The DCS/Nurse Manager will re-educate the nursing staff on providing 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 by October 28, 2014; emphasis will be placed on providing an assistive</p>	10/30/2014

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 09/30/2014	
NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069			
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	<p>unit-Supervision/Setup help</p> <p>The resident had a Care Plan, dated 6/26/14, that addressed a problem of she had right handed multiple sclerosis as evidenced by shaking, tremors, back pain and decreased walking.</p> <p>Approaches included, but were not limited to, 6/14/14-resident was up ad lib (independently) with a rollator walker.</p> <p>On 9/25/14 at 9:10 A.M., LPN #6 was observed giving Resident #36 her medication. At that time, the resident asked LPN #6 where her walker was located and indicated she needed her walker. LPN #6 indicated she did not know where the resident's walker was located, then she washed her hands and left the room. The resident's walker was observed behind a privacy curtain that was pulled across the foot of the bed.</p> <p>During an interview on 9/26/14 at 1:10 P.M., the Director of Clinical Services indicated he expected the nursing staff to give the residents their assistive devices when they need them.</p> <p>This Federal Tag relates to Complaint IN00155737</p> <p>3.1-3(p)(1)</p>		<p>device to a resident when requested.</p> <p>4. The DCS/Nurse Manager will conduct QI monitoring of the regulation F241 to ensure residents are provided assistive devices when requested. QI monitoring will be conducted via observation or resident interview five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months using a sample size of five residents utilizing an assistive device. The DCS/Nurse Manager will report findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring,</p> <p>5. Date of Compliance: October 30, 2014</p>				

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  09/30/2014	
NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069			
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F000242 SS=D	<p>3.1-3(t)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review, the facility failed to honor preferences in regards to bathing for 1 of 1 residents reviewed for choices in a sample of 5. (Resident #24)</p> <p>Findings include:</p> <p>On 9/24/14 at 11:10 a.m., the record review for Resident #24 was completed. Diagnoses included, but were not limited to depression, diabetes and high blood pressure.</p> <p>The most recent full MDS (Minimum Data Set) assessment, dated 12/27/13, indicated the resident expressed her preference to choose between tub bath, shower or bed bath as somewhat important.</p> <p>On 9/23/2014 9:07 a.m., Resident #24</p>	F000242	<p>F-242</p> <p>1. The nurse tech kardex and the bath schedule were updated on 10/16/14 to reflect Resident # 24's preference to take a bath.</p> <p>2. All residents have the potential to be affected by this alleged deficient practice. On 10/16/14 residents were interviewed by a licensed nurse and asked if they were satisfied with receiving a shower. The nurse tech kardex and bath schedule was updated to reflect preference for those residents expressing a preference for a tub bath, whirlpool or bed bath.</p> <p>3. The RDCS will re-educate the Department Heads on the regulation F 242 and the facility's bathing policy by October 27, 2014. The DCS/ Nurse Manager will re-educate</p>	10/30/2014			

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  09/30/2014
NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069		
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F000246 SS=D	<p>indicated she preferred to take a bath as that was what she had always done at home.</p> <p>On 9/29/14 at 9:50 a.m., the Activity Director indicated she asked the residents when they were admitted what their choices were in regards to bathing. She indicated she asked if they had a preference and most of the residents were all right with doing a shower. She indicated if they wanted a tub bath, whirlpool or bed bath she "jots" a note down and gave it to nursing for follow-up. She indicated there was no documentation regarding this.</p> <p>This Federal Tag relates to Complaint IN00155737</p> <p>3.1-3(v)(1)</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive</p>		<p>the nursing staff on the facility's bathing policy and on the regulation F242 by October 28, 2014.</p> <p>4. The Social Service Director (SSD)/ Nurse Manager will conduct QI monitoring of the regulation F242 to ensure resident preferences in regards to bathing are honored. QI monitoring will be conducted five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months using a sample size of five random residents. The SSD/Nurse Manager will report findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring,</p> <p>5. Date of Compliance: October 30, 2014</p>		

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 09/30/2014	
NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069			
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	<p>services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on interview and record review, the facility failed to accommodate a bariatric resident in regards to use of a bedpan for 1 of 1 residents reviewed for accomodation of needs in a sample of 5. (Resident C).</p> <p>Findings include:</p> <p>On 9/24/14 at 10:45 a.m., the record review for Resident C was completed. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease, depression, morbid obesity, urinary incontinence and insomnia.</p> <p>On 9/23/2014 at 02:30 p.m., a urine odor was noted when sitting near the resident's bed.</p> <p>The progress notes indicated on "8/9/14 at 11:00 p.m., ...Continent of urine and feces-utilizes bed pan...8/10/14 at 6:00 a.m., ...Resident is continent but has been urinating in the bed-states that the bed pan 'collapses' under her weight...10:30 p.m.,... bed pan not 'strong enough to support weight',...had to wait until September to see the Urologist regarding surgery on her bladder...8/11/14 3:00</p>	F000246	<p>F-246</p> <ol style="list-style-type: none"> <li>Resident C has a bariatric bed side commode in the room and a bariatric bed pan has been purchased.</li> <li>Bariatric residents have the potential to be affected by this alleged deficient practice. A member of the Interdisciplinary Team (including Nurse Manager, SSD, Activities Director, and Minimum Data Set Coordinator) will review bariatric for accommodation of needs by October 27, 2014. Any issues identified will be addressed immediately</li> <li>The RDCS will re-educate the Department Managers on the regulation F 246 and the facility's Grievance/Concern policy. DCS/Nurse Manager will re-educate the nursing staff on the regulation F246 and on the facility's Grievance/Concern policy by October 28, 2014.</li> <li>The DCS/Nurse Manager will conduct QI monitoring of the regulation F246 to ensure bariatric residents' needs are accommodated. QI monitoring will be conducted</li> </ol>	10/30/2014			

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  09/30/2014
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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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(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
F000248 SS=D	<p>a.m., resting quietly, call light in reach, refusing bed pan, voiding large quantity of urine, complete bed change's made...pericare after each incontinent episode...8/30/14 3:00 p.m.,...Incontinent of bowel and bladder at times due to large size doesn't fit bed pan...."</p> <p>On 9/26/14 at 2:00 p.m., additional information was requested from the Director of Clinical Services related to the "collapsing bed pan" and if any other accommodations were made for toileting.</p> <p>As of the exit conference on 9/30/14 at 2:00 p.m., no additional information was provided.</p> <p>This Federal Tag relates to Complaint IN00155737</p> <p>3.1-3(v)(1)</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on record review, observation and</p>	F000248	<p>via observation or resident interview five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months using a sample size of three bariatric residents. The DCS/Nurse Manager will report findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring,</p> <p>5. Date of Compliance: October 30, 2014</p> <p>1. Residents # 66 and 57 no</p>	10/30/2014

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  09/30/2014
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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>interview, the facility failed to provide individualized activity plans to meet the resident needs for 3 of 4 residents with maladaptive behaviors reviewed for individualized activity plans. (Resident # 66, # 57, # 33).</p> <p>Findings include:</p> <p>1. The record review for Resident #66 was reviewed on 9/24/14 at 11:09 A.M. Diagnoses included, but were not limited to, dementia with behavior disturbances, cognitive communicative deficit, psychological disease with hallucinations, impulsivity and behavior disturbances, anxiety and depression related to illness and chronic insomnia.</p> <p>The resident had a Care Plan, dated 9/12/13, that addressed the problem of activities. Approaches included, but were not limited to, "9/10/13-1) Let Nursing know to have ready. 2) Assist to &amp; [and] from...4) praise him for participating [sic] Sit @ [at] table to do table act. [activities] Large Legos, Blocks, Wooden trains, Working in dirt &amp; flowers, Outside sits."</p> <p>The resident's Significant change Minimum Data Set assessment, dated 4/7/14, indicated the resident preferred being around animals and pets, listening</p>		<p>longer reside at the facility. Resident #33's activity care plan was reviewed and updated by the Activities Director on 10/17/14 2. All residents have the potential to be affected by this alleged deficient practice. Residents with maladaptive behaviors will be reviewed for individualized activity care plans by the Activities Director by October 28, 2014. 3. On October 7, 2014 the RDCS re-educated the Activities Director on the regulation F 248 and the facility's policies on: Activity Program, Activity Assessment, Activity Care Plan, Conducting Activities, Participation in Activities, Safety and Supervision of Residents, Supplies and Equipment, and Progress Notes. The Activities Director received education from an outside consultant on October 17th and 22nd, 2014 on the regulation F 248, Behavior Management Intervention and Care Development. The outside consulting company will provide ongoing consulting monthly for six months. 4. The Activities Director/ SSD will conduct QI monitoring of the regulation F248 to ensure individualized activity care plans to meet the needs of residents with maladaptive behaviors. QI monitoring will be conducted via observation and/or record review five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for</p>	

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  09/30/2014	
NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069			
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	<p>to music, spending time outdoors and participating in religious activities or practices.</p> <p>The resident's "Activity Plan of Care Progress Note", dated 8/15/14, indicated his activity interests were "Household tasks, Starlight and Falling Star activities."</p> <p>A document titled "Activity Participation Record" included, but was not limited to, the following activities the resident participated in on the following months:</p> <p>The record, dated July 2014, indicated this resident was actively participating in: Snacks daily except on 7/13/14 through 7/15/14 when the resident had not attended, Exercise, Music, Radio, CD's, TV, Movies, Videos daily and Starlight daily while he wandered during the activity.</p> <p>Resident #66 attended a Birthday party, watched a movie, listened to a musical entertainment activity, attended a church activity and the Ice cream social, but his record lacked documentation whether the resident was actively participating in these activities during July.</p> <p>The record, dated August 2014, indicated</p>		<p>three months using a sample size of three residents with maladaptive behaviors. The Activities Director/ SSD will report findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring, 5. Date of Compliance: October 30, 2014</p>				

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  09/30/2014
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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>this resident was actively participating in "Snacks daily except 8/24/14 and 8/25/14 and 8/27/14 through 8/29/14 when he refused, Exercise (Walks), Music, Radio, CD's, Falling Star except 8/16/14 through 8/28/14 when he wandered or was in bed, and Household Tasks except 8/2/14 and 8/3/14, 8/13/14 through 8/31/14 when he was not at the activity."</p> <p>He attended a Birthday party, a pet visit activity, the Ice cream social and listened to a musical entertainment, but his record lacked documentation whether the resident was actively participating in these activities during August.</p> <p>The record dated September 2014, indicated this resident had actively participated in "Snacks daily except 9/1/14 through 9/3/14, and 9/6/14 because he refused, Exercise, Music, Radio, CD's, TV, Movies, Videos, Household Task, Starlight and Falling Star program except when he wandered in and out of the activity, was in bed or refused to attend the activity."</p> <p>He attended an Entertainment/special event, a church activity, and the Ice cream social, but his record lacked documentation whether the resident was actively participating in these activities during September.</p>			

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  09/30/2014
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	<p>On 9/23/14 at 9:35 A.M., the resident was observed to have his eyes closed and could not be aroused. At that time CNA #12 indicated he was always hard to arouse. The activity scheduled at 9:30 A.M. was (Name of person) played the piano.</p> <p>On 9/23/14 at 10:57 A.M., the resident was observed to have his eyes closed and could not be aroused. The activity scheduled at 10 A.M. was Household Tasks.</p> <p>On 9/23/14 at 11:47 A.M., CNA #9 was observed ambulating the resident to lunch. The resident was leaning to the left while walking to the dining room and CNA #9 indicated that was not "like him" to lean while he was ambulating.</p> <p>On 09/23/2014 at 3:19 P.M., the resident was observed to have his eyes closed and could not be aroused. The activity scheduled at 2 P.M. was crafts.</p> <p>On 9/23/14 at 5:00 P.M., the resident was observed to be awake and pulled at his blankets on his bed. There was no scheduled activity at this time.</p> <p>During an interview on 9/23/14 at 5:12 P.M., LPN #3 indicated Resident #66</p>			

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  09/30/2014
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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>was usually up walking around by himself on evenings "getting into everything."</p> <p>On 9/24/14 at 11:00 A.M., the resident was observed sitting in a recliner in the North end lounge. The recliner was tipped back with his feet propped up with the bottom of the recliner. He was observed with his eyes closed. At that time Activities Staff Member #13 was observed playing ring toss with Resident #33 and spelling words with Resident #47.</p> <p>On 9/24/14 at 11:44 A.M., CNA #12 and LPN #5 were observed transferring Resident #66 out of the recliner chair to ambulate him. At that time, CNA #12 indicated to LPN #5 regarding Resident #66, "He slept all the way through activities didn't he?" At that time, LPN #5 indicated he had slept through the activities.</p> <p>On 9/24/14 at 1:10 P.M., Resident #66 was sitting at a table unattended in the North end lounge. The TV in the lounge was playing, but the resident had his back to the TV. There was no scheduled activity at this time.</p> <p>During an interview on 9/29/14 at 4:05 P.M., the Activity Director indicated on</p>			

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 09/30/2014	
NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069			
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	<p>9/23/14 in the main dining room and 9/24/14 in the North end lounge at 10:00 A.M., Resident #66 was an active participant in both those activities. She indicated the "A" on the "Activity Participation Record" indicated the resident actively participated in the activity, "W" indicated the resident wandered during the activity, "R" indicated the resident refused the activity.</p> <p>2. The record for resident # 57 was reviewed on 9/26/14 at 8:21 a.m. Current diagnoses included, but were not limited to, dementia with behavior disturbances and psychiatric disorder with delusions.</p> <p>A Quarterly Minimum Data Set (MDS) assessment, dated 7/8/14, indicated the resident wandered on 4-6 days and was physically aggressive on 1-3 days of the assessment period.</p> <p>A plan of care, dated 5/12/14 and updated 8/12/14, indicated the resident wandered into others' rooms, with approaches that included, but were not limited to, "redirect inappropriate behavior as needed." The goal indicated the resident would wander safely and be directed away from others rooms daily.</p> <p>A plan of care, updated 8/5/14, indicated the resident was dependent on staff for activities, cognitive stimulation, and</p>						

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>social interactions. Approaches included, and were not limited to, "porch sitting, 1:1 activities, adapt activities to attention span and cognitive level, relaxation programs, small group activities and resident preferred activities of music, household task, starlight, outside sits, stacking cups and walks outside with staff."</p> <p>A social service note, dated 7/9/14, indicated the resident was up frequently during the night and easily annoyed.</p> <p>A 7/16/14 social service note indicated the resident wandered frequently throughout the night.</p> <p>Nurses notes indicated: "6/19/14 at 10 p.m., continued to wander and entered several other resident rooms. The other residents used call lights to alert the resident was in their room. Urinated in one of the other resident rooms. 6/20/14 at 6 a.m., continued to wander into others rooms. 6/21/14 at 5 a.m., continued to wander into others rooms. 6/22/14 resident wandered up and down the halls 6/24/14 at 10 p.m., wandered into resident rooms many times throughout the evening requiring 1:1 supervision.</p>			

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 09/30/2014	
NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069			
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	<p>6/27/14 and 6/28/14 continued to wander into others rooms.</p> <p>7/1/14 at 3 a.m., wandered into other resident rooms.</p> <p>7/4/14 at 6 a.m., wandered into other resident rooms.</p> <p>7/5/14 at 11:14 p.m., ...has continued to be active, mobile and going in other residents' rooms...</p> <p>7/15/14 at 2:35 p.m., has exhibited aggressive behavior toward staff, hitting CNA in the stomach and twisting the thumb of a nurse. Has been wandering into other resident rooms needing frequent redirection.</p> <p>7/23/14 at 9 p.m., resident was up wandering all shift continues on 15 minute checks, easily redirected, but continues to wander in and out of other resident rooms.</p> <p>7/24/14 at 9 p.m., continued to wander facility, enters other resident rooms, staff redirected multiple times when resident was found in other resident rooms. Continued on 15 min checks.</p> <p>7/28/14 at 4 a.m., continued to wander into other resident rooms, on 15 minute checks.</p> <p>8/3/14 started on an antibiotic and on 8/11/14 he was in a wheelchair.</p> <p>8/20/14 at 9 p.m., wandered up and down the halls and in and out of other resident rooms."</p>						

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>The Activity participation record for: September 2014 indicated the resident actively participated in "starlight" daily and wandered during these activities for 23/25 days. The record indicated the resident attended ice cream once, church once, entertainment once and one walk outside. He had an "A" every day in the box for exercise, music, radio, CD, TV, movie, video.</p> <p>August 2014 indicated he participated in "starlight" daily with wandering and confusion for 19/30 days and actively participated 4/30 days. He participated in "household tasks" with wandering 15/30 days and "starlight" with wandering 4/30 days. He attended entertainment 5 times, bible study once, ice cream once, and went outside 3 times.</p> <p>July 2014 indicated he participated in "starlight" daily with wandering 25/30 days and "household tasks" with wandering 15/30 days. He attended ice cream 2 times, entertainment 3 times, birthday party, church 2 times, and movies once. He had one to one checked with no time indicated for 15/30 days.</p> <p>July, August and September 2014 records had an "A" in the "exercise box" indicating he walked, and was provided music, radio, CD, TV, movies videos.</p>			

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>During an interview with the Activity Assistant on 09/29/2014 at 9:36 A.M., she indicated the resident liked big Legos and she would use them for his activities. She indicated he had no specific activity plan in place for his wandering.</p> <p>3. The record for Resident # 33 was reviewed on 9/26/14 at 9:27 a.m. Current diagnoses included, but were not limited to, dementia with behavioral disturbances.</p> <p>An 8/7/14 quarterly MDS indicated the resident did not wander and had physically abusive behaviors 4-6 days and verbally abusive 1-3 days.</p> <p>A 6/17/14 activity progress note indicated his interests included but were not limited to, games, music, news, pets, religion and TV.</p> <p>A plan of care, dated 9/22/14, indicated the resident was combative with care, hitting, grabbing and yelling. The plan also indicated he wandered about the facility and his behavior would escalate with redirection. Approaches included, but were not limited to, "redirect the resident by talking to him about his wife."</p>			

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069			
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	<p>A plan of care, dated 1/16/14 and updated 9/9/14, indicated the resident wandered in and out of activities with a goal to stay in activities at least 20 minutes daily. Approaches included, but were not limited to, "encourage him to stay, call out name to keep his attention, bring to household task, starlight, church, ice cream, music, large Legos, talk about family farm." There was no date on the interventions to indicate when they were added.</p> <p>The Activity participation record for September 2014 indicated the resident refused snacks, actively participated in exercise by propels, had wife visits, had music, radio or cd, movies or videos daily. He attended church 3 times, had 2 walks outside and attended a birthday party and had ice cream twice. The record indicated the resident attended "starlight" which was an evening program.</p> <p>August 2014 participation record indicated the resident participated in "starlight" 27 days, "household tasks" 27/30 days, entertainment 5 times, ice cream 2 times, church 2 times, Bible study and a birthday party and participated in "falling stars" 13/30 days.</p> <p>July 2014 participation record indicated</p>						

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  09/30/2014
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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
---	--

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	<p>the resident participated in "starlight" daily, "household tasks" daily, attended church 4 times, Bible study 2 times, ice cream one time, a birthday party and entertainment 3 times.</p> <p>The July and September activity participation record indicated he wandered in and out of the activities.</p> <p>The Activity Director, on 09/29/2014 at 4:12 P.M., indicated during interview that starlight and household tasks included, Lego's, stacking cups, putting flowers in vases, ring toss and other events for lower functioning residents. Falling stars was an evening activity program. She indicated she could not say how long the resident participated. She indicated the "A" in exercise meant the resident could propel self and the "W" meant the resident wandered. The "A" in Music, Radio and CD, TV Movies and Video meant while the resident was in the dining room or lounge one of these items were playing.</p> <p>During an interview with the activity assistant on 09/29/2014 at 9:36:49 A.M., she indicated the resident liked big Legos and she would use them for his activities. She indicated he wandered in and out of the activities and had no specific activity plan in place for his</p>			

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069			
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	<p>wandering.</p> <p>4. The Activity calendar included, but was not limited to, the following activities in these months on the following dates and times:</p> <p>July 2014: 10:30 A.M.-Household Tasks daily this month Monday through Friday. 2:00 P.M.-Country Ride on 7/24/14 and 7/31/14. 3:00 P.M.-Ice Cream Social every Sunday this month. 6:00 P.M.-Saturday Night at the Movies every Saturday evening.</p> <p>August 2014: 10:00 A.M.-Household Tasks daily this month Monday through Thursday. 2:00 P.M.-Country Ride on 8/7/14, 8/14/14, and 8/21/14. 3:00 P.M.-Ice Cream Social every Sunday this month. 6:00 P.M.-Saturday Night at the Movies every Saturday evening. 6:30 P.M.- Starlight Every Evening this month except on Fridays and Sundays.</p> <p>September 2014: 10:00 A.M.-Household Tasks daily this month Monday through Thursday. 2:00 P.M.-Country Rides on 9/4/14 and 9/25/14. 3:00 P.M.-Ice Cream Social every</p>						

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069			
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	<p>Sunday this month. 6:00 P.M.-Falling Star-Saturday Night at the Movies every Saturday this month. 6:15 P.M.-Falling Star daily this month Sunday through Friday. 6:30 P.M.-Starlight daily this month every evening.</p> <p>The Activity Director indicated the activity category "Exercise" on the Participation record indicated for the dementia wandering residents that they ambulated, not that they necessarily exercised in a group activity. She indicated the "Starlight" program was for the lower functioning dementia individuals, which involved activities such as; ring toss, blocks, kickball, coloring, wood blocks and legos. The Activity Director indicated the "Falling Star" program was for the dementia residents who are higher functioning, but who are at risk for falls, which involved activities such as; card games, yahtzee, table games and dominoes, so they could sit at the table and play these games. She indicated she had not documented the length of time the residents were active during activities. She indicated when the activities such as music, radio, CD's, movies and videos were playing in the lounge and main dining room, the residents with dementia, with wandering behaviors, wandered in and out of these</p>						

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

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	<p>activities.</p> <p>During an interview on 9/29/14 at 5:15 P.M., the Activity Director indicated the Activity Department's documentation of the residents activities needed improvements. She indicated the "Household Tasks" activity was not an activity that was just scheduled at a specific time in the A.M. She indicated it lasted all day because the activity and nursing staff would try to get the wandering dementia residents to perform these tasks all day long to keep them busy and entertained.</p> <p>During an interview on 9/30/14 at 11:10 A.M., the Activity Director indicated the "outdoor sits" and "placing flowers in dirt" activity fell under the household tasks activity and that was where she documented those activities. She indicated she knew she had problems with the way the activities were documented and she needed to fix that problem. The Activity Director indicated Resident #66 had not actively participated in any activity for more than 10 minutes before he wandered away or she had to remove him from an activity because he was taking another resident's things. She indicated he wandered into the main dining room during bingo and took the other residents' bingo chips and</p>			

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--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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F000250 SS=E	<p>they had not wanted him in there during activities. She indicated she had a difficult time trying to keep Residents #57 and #33 focused on activities due to wandering.</p> <p>3.1-33(a)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure psychological / well-being follow-up for 6 of 6 residents reviewed for follow-up after instances of behaviors in a sample of 6 (Resident #56, #36, #D, #67, #14, and #66) and failed to initiate a behavior plan of care timely for verbal outbursts for 1 of 4 resident reviewed for verbal aggression in a sample of 4. (Resident #56)</p> <p>Finding include:</p> <p>1. The record for Resident #56 was reviewed on 9/29/14 at 12:15 P.M. Current diagnoses included, but were not limited to traumatic brain injury, anoxic brain injury, dementia with behavior disturbances, affective personality</p>	F000250	<p>F-250</p> <p>1. Residents # 56 and 66 no longer reside at the facility. The SSD will follow up with residents # 14, 24, 36, 66, 67, and D to ensure psychological/ well-being by October 24, 2014.</p> <p>2. All residents have the potential to be affected by this alleged deficient practice. The nurses' notes, behavior documentation notes, resident grievance/concerns, and resident interviews for the month of October, 2014 will be reviewed for the need for psychological/ well-being follow up by a member of the IDT for current in-house residents by October 28, 2014. Any issues identified will be addressed immediately.</p> <p>3. On October 20, 2014 the RDCS re-educated the SSD on the</p>	10/30/2014

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 09/30/2014	
NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069			
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	<p>disorder.</p> <p>The, "Interdisciplinary progress notes &amp; comments," indicated Resident #56 had several confrontations with other residents on 9/7/14. It indicated Resident #56 verbally threatened Resident #36 with, "I will kill you." Then she verbally threatened Resident #14, "she was going to kick her a-s." The resident also verbally threatened Resident #24 by indicating, " I f---ing hate you, you should die..." Then the notes indicated, Resident D reported that Resident #56 wants to "kill them...", then, " in dining room ... [Resident #67] stated he would be leaving resident [#56] misunderstood and started yelling the F---- word..." The notes indicated the nurse, "...spoke with [symbol for with] resident one on one, told her she shouldn't be yelling at others and cursing because its [sic] not acceptable...."</p> <p>Social Service notes indicated "9/8/14 spoke with resident about statements made to residents and resident stated 'I would not hurt them. I don't like it here.'" Social Service Designee (SSD) indicated she would try to find other placement for the resident.</p> <p>Additional information was requested from the SSD on 9/29/14 at 3:30 p.m.</p>		<p>regulation F250 and the facility's policies on: Social Services, Team Approach, Progress Notes, and Episodic Notes. The SSD received education from an outside consultant on October 17th and 22nd, 2014 on the regulations F250 &amp; F225, Care Plan development and Behavior Management. The outside consulting company will provide ongoing consulting monthly for six months.</p> <p>4. The SSD/ Activities Director will conduct QI monitoring of the regulation F250 to ensure psychological /well-being follow up after instances of behaviors and ensure behavior care plans are initiated timely. QI monitoring will be conducted via observation and/or record review five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months using a sample size of five random residents. The SSD/ Activities Director will report findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and</p>				

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  09/30/2014
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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>regarding follow- up with the residents about the above event.</p> <p>On 9/29/2014 at 3:30 P.M., the SSD indicated a behavior careplan was initiated on 9/22/14 for Resident # 56. The plan of care, dated 9/22/14, indicated the resident did not think before she spoke and would threaten to kill staff and residents. She would curse and use vulgar language, had hit a nurse and had a history of physical behaviors towards staff.</p> <p>A resident profile for behavior interventions was dated 9/22/14 with interventions for her behaviors. It indicated that if the resident became verbally or physically unmanageable staff should assure the resident's safety and safety of other residents and allow her time to cool off.</p> <p>On 09/29/2014 at 3:47 P.M., an IDT (interdisciplinary Team) note was provided that indicated on 9/23/14 Resident # 36 was asked if she was fearful of anyone in the facility and she had replied "no".</p> <p>On 09/29/2014 at 3:47 P.M., an IDT note was provided that indicated on 9/23/14 Resident D was asked if she was fearful of anyone in the facility and she</p>		<p>determine the continued time schedule for further monitoring,</p> <p>5. Date of Compliance: October 30, 2014</p>	

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  09/30/2014
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	<p>had replied "no".</p> <p>On 09/29/2014 at 3:47 P.M., an IDT note was provided for Resident # 14 that indicated, on 9/23/14, the resident was asked if she was fearful of anyone in the facility and she had replied "no".</p> <p>On 09/29/2014 at 3:47 P.M., an IDT note was provided for Resident # 67 that indicated it was a late entry note for 9/23/14. The note was dated 9/29/14 and indicated the resident was asked if he was fearful of anyone in the facility. The resident had replied "no".</p> <p>On 09/30/2014 at 9:53 A.M., during an interview with the SSD, she indicated she should have followed up with the residents involved in the 9/7/14 occurrence before 9/23/14. She also indicated there had not been a Behavior Management meeting since July when she came back to work.</p> <p>2. The record for Resident #66 was reviewed on 9/24/14 at 11:09 A.M. Diagnoses included, but were not limited to, dementia with behavior disturbances, cognitive communicative deficit, psychological disease with hallucinations other disease, impulsivity and behavior disturbances, anxiety and depression related to illness, and chronic insomnia.</p>			

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>The resident was readmitted to the facility after an admission at a Geriatric Psychiatric Hospitalization in March 2014.</p> <p>A document titled "Psychiatry Progress Note and Treatment Summary", dated 7/24/14, indicated "Asked to see emergently, with more anger, aggression and quite agitated...Quick to anger...Poor Judgement...Progressive decline with intense anger/aggression now... Impression/Plan: Medications: 1. Increase Depakote Sprinkle [Mood Stabilizer medication] to 250 mg [milligrams] Q [every] A.M. &amp; 375 mg Q 5 P.M. 2. Resume Risperdal [An Antipsychotic medication] 0.25 mg Q 5 P.M. (delusions/aggression) 3. Cont [continue] Klonopin [An anti-anxiety medication] 0.25 mg Q 5 P.M. 4. Now Zoloft [An Anti-depressant medication] 75 mg Q A.M. (Recent increase) Behavioral Recommendations: He remains impulsive &amp; lacks safety awareness. May be better on a secured dementia unit."</p> <p>The Interdisciplinary Progress Notes had indicated the resident had intrusively wandered into other resident's rooms on the following dates: 7/22/14--The resident was wandering all evening into multiple residents' rooms</p>			

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	<p>and became somewhat hostile at times.</p> <p>7/23/14--The resident was found face down on the floor in another resident's room. He cussed at the staff during the assessment.</p> <p>8/6/14--The resident continued to wander into other residents' rooms and took their food and drinks. He became combative when the staff attempted to redirect him.</p> <p>8/7/14--The nurse sent a fax to the Physician in regards to the resident wandering into other residents' rooms and taking their things. He became combative and hit staff when they attempted to redirect him.</p> <p>9/13/14--The resident wandered up and down the hallways and in and out of the residents' rooms.</p> <p>9/15/14--The resident wandered up and down the hallways and into other residents' rooms</p> <p>The Interdisciplinary Progress Notes indicated the resident had resident to resident altercations. On 7/22/14 at 6 A.M., Resident #8 reported that Resident #66 hit and grabbed her left upper arm as he tried to enter her room.</p> <p>On 7/24/14 at 5:30 P.M., Resident #66 walked into Resident #82's room where he and a family member were visiting with his dog. Resident #66 started to pet Resident #82's dog, then became agitated</p>						

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>and cursed at the dog. Resident #66 picked up a pillow and threw it at Resident #82.</p> <p>On 8/19/14 at 7:20 A.M., Resident #66 was ambulating in the North hallway common area when he grabbed Resident #68's arm. Resident #68 raised his fist to Resident #66 and Resident #66 raised his fist back to him.</p> <p>An Interdisciplinary Progress Note, dated 7/24/14, indicated the Social Service Designee (SSD) was notified of the resident to resident altercation that had occurred on 7/24/14, for further evaluation and follow-up with the resident.</p> <p>The Interdisciplinary Progress Notes indicated the following notes from the Social Service Designee: On 7/24/14, she indicated she was informed of the resident to resident altercation that occurred on 7/22/14 between this resident and Resident #8. She indicated she was informed of the resident to resident altercation that occurred on 7/24/14 between this resident and Resident #68. She indicated the resident was placed on 1:1 intervention after the 7/24/14 resident to resident altercation.</p>			

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	<p>On 7/26/14, she indicated the resident remained on 1:1 intervention. She indicated a late entry for 7/24/14, the Psychiatrist saw the resident to review his medications and new orders were written.</p> <p>The State Agency Incident Report Form, dated 7/22/14, indicated the residents involved in the altercation would have followed up with Social Services to ensure there were no psychosocial concerns.</p> <p>The State Agency Incident Report Form, dated 7/24/14, indicated the Social Service Designee (SSD) was made aware of the incident.</p> <p>The Interdisciplinary notes lacked documentation of follow-up from the SSD concerning the residents' psychosocial needs after any of the resident to resident altercations on 7/22/14, 7/24/14 or 8/19/14.</p> <p>The Interdisciplinary notes lacked documentation of follow-up from the SSD with the resident's family member concerning transferring him to a facility with a secured dementia unit as recommended in the Psychiatrist Progress Note on 7/24/14.</p> <p>During an interview on 9/25/14 at 4:50</p>			

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F000256 SS=E	<p>P.M., the SSD indicated she was the staff member responsible for contacting a family member and discussing transferring their loved one to a facility with a secured dementia unit. She indicated she had not contacted the resident's family member who was responsible for him until 9/25/14, regarding placing him on a secured dementia unit. She indicated the family member indicated she would talk to the rest of the family and let her know, but she was not surprised and had been expecting this.</p> <p>The SSD indicated she had not documented any follow up on this resident since 7/26/14. She indicated she thought she had followed up on his psychosocial needs after the resident to resident altercations on 7/22/14 and 7/24/14, but after she reviewed the Interdisciplinary Progress Notes she indicated she had not followed up with the resident.</p> <p>3.1-34(a)(1) 3.1-34(a)(2)</p> <p>483.15(h)(5) ADEQUATE &amp; COMFORTABLE LIGHTING LEVELS</p>				

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>The facility must provide adequate and comfortable lighting levels in all areas. Based on observation and interview, the facility failed to have light fixtures that were in good working order for 3 of 8 rooms observed for properly functioning lighting. (Rooms 203, 208 and 219)</p> <p>Findings include:</p> <p>On 09/25/2014 at 10:44 A.M., the over the bed lighting in Room 203 bed A and bed B did not fully light up. The upper light did not turn on when the light cord was pulled.</p> <p>On 09/25/2014 10:46 A.M., the over the bed lighting in Room 208 bed A and bed B did not fully light up. The upper light did not turn on when the light cord was pulled for bed B and the lower light did not turn on when the cord was pulled for bed A.</p> <p>On 09/25/2014 10:52 A.M., the over the bed lighting in room 219 bed A did not fully light up, only the upper light turned on when the cord was pulled.</p> <p>During an environmental tour with the Maintenance Supervisor on 09/25/2014 at 1:25 P.M., the Maintenance Supervisor indicated the lights in the identified rooms were not working properly. He</p>	F000256	<p>F-256</p> <ol style="list-style-type: none"> <li>No resident was identified. On 9/26/14 the Maintenance Director installed new lighting fixtures in Rooms 203 bed A and bed B, 208 bed A and bed B, and 219 bed A.</li> <li>All residents have the potential to be affected by this alleged deficient practice. The Maintenance Director completed a house wide audit of the resident rooms to ensure light fixtures were in good condition on 10/07/2014.</li> <li>The Maintenance Director will order four above the bed lights monthly to replace the older fixtures until all of the above the bed fixtures have been updated.</li> <li>The ED/ Maintenance Director will conduct QI monitoring of regulation F256 to ensure light fixtures are in good working order. The QI monitoring will be conducted weekly for three months and then monthly for three months. The ED/Maintenance Director will report findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring.</li> </ol>	10/30/2014

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  09/30/2014
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F000280 SS=E	<p>indicated he had replaced one room with a new light but it was difficult to obtain the ballast for the light fixture since they were older lights.</p> <p>3.1-19(f)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to revise Care Plans with appropriate interventions for activities and wandering behaviors (Resident #66, #57 and #33) and accidents (Resident #47) for 4 of 35 residents reviewed for Care Plan revision.</p> <p>Findings include:</p>	F000280	<p>5. Date of Compliance: October 30, 2014</p> <p>F-280</p> <p>1. Residents # 57 and 66 no longer reside at the facility. Resident #33's activity care plan was reviewed and updated by the Activities Director on 10/17/14. The IDT will review the care plan, nurse tech kardex and physician's orders for resident #47 by 10/24/14 to ensure fall preventative</p>	10/30/2014

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  09/30/2014
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	<p>1. The record for Resident #66 was reviewed on 9/24/14 at 11:09 A.M. Diagnoses included, but were not limited to, dementia with behavior disturbances, cognitive communicative deficit, psychological disease with hallucinations other disease, impulsivity and behavior disturbances, anxiety and depression related to illness and chronic insomnia.</p> <p>The resident's Significant change Minimum Data Set assessment, dated 4/7/14, indicated the resident indicated he preferred being around animals and pets, listening to music, spending time outdoors and participating in religious activities or practices.</p> <p>The resident's "Activity Plan of Care Progress Note", dated 8/15/14, indicated his activity interests were Household tasks, Starlight and Falling Star activities.</p> <p>The resident had a Care Plan, dated 8/12/13, that addressed the problem of the resident being sensitive to care, resistive to care, having poor safety awareness and impulse control, having cursed, hit and kicked staff, wandered, refused care and attempted to take other residents' food.</p> <p>Approaches included, but were not</p>		<p>interventions are in place.</p> <p>2. All residents have the potential to be affected by this alleged deficient practice.</p> <p>Residents with maladaptive behaviors will be reviewed for individualized activity care plans by the Activities Director by October 28, 2014.</p> <p>IDT will review and revise, as indicated, the care plan for residents with wandering behaviors by October 27, 2014.</p> <p>The care plan, Nurse Tech Kardex, and physician's orders for residents who had fallen in the last 30 days were reviewed by the Falls Committee on 10/08/14 to ensure appropriate fall interventions were in place. Any issues identified were corrected immediately.</p> <p>3. The RDCS will re-educate the IDT on the regulation F280 and the facility's care plan policy emphasis will be placed on revising care plans with appropriate interventions by October 27, 2014.</p> <p>On October 7, 2014 the RDCS re-educated the Activities Director on the regulation F 248 and the facility's policies on: Activity Program, Activity Assessment, Activity Care Plan, Conducting Activities, Participation in Activities, Safety and Supervision of Residents, Supplies and Equipment, and</p>	

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	<p>limited to, "8/10/13--Resident without touching, call the resident by name, tell him to stop, be kind but firm...Ensure safety, re-approach, Change caregiver...1/14/14--Redirect with act when wandering...."</p> <p>The resident had a Care Plan, dated 9/12/13, that addressed the problem "Resistive to care due to decreased comprehension and progressive dementia and 8/5/14 required antipsychotic and antidepressant medications."</p> <p>Approaches included, but were not limited to, "1/10/12--...Monitor for behaviors...."</p> <p>The resident had a Care Plan, undated, that addressed the problem of physical behavior toward other residents.</p> <p>Approaches included, but were not limited to, "7/31/14--1. Redirect resident away from peers rooms...8/15/14--3. Walk with the resident...5. At first sign of frustration separate from source of agitation and take to an area where he can gain a sense of calm."</p> <p>The resident had a Care Plan, dated 9/12/13, that addressed the problem of activities. He had preferences of woodworking, gardening, and being</p>		<p>Progress Notes. The Activities Director received education from an outside consultant on October 17th and 22nd, 2014 on the regulation F 248, Behavior Management Intervention and Care Development. The outside consulting company will provide ongoing consulting monthly for six months.</p> <p>On October 20, 2014 the RDSCS re-educated the SSD on the regulation F250 and the facility's policies on: Social Services, Team Approach, Progress Notes, and Episodic Notes. The SSD received education from an outside consultant on October 17th and 22nd, 2014 on the regulations F250 &amp; F225, Care Plan development and Behavior Management. The outside consulting company will provide ongoing consulting monthly for six months.</p> <p>On 9-25-14, the Regional Director of Clinical Services re-educated the Interdisciplinary team (IDT) including the Executive Director, Director of Clinical Services, Social Services Director, Activities Director, Assistant Director of Clinical Services and Minimum Data Set (MDS) Coordinator on the Behavior Management, Behavior Monitoring, Accident and Incident Reporting and Investigating, and Abuse Reporting and the Investigation Process.</p>				

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	<p>outside.</p> <p>Approaches included, but were not limited to, "9/10/13-1) Let Nursing know to have ready. 2) Assist to &amp; [and] from...4) praise him for participating [sic] Sit @ [at] table to do table act. [activities] Large Legos, Blocks, Wooden trains, Working in dirt &amp; flowers, Outside sits"</p> <p>"Behavior Detail Report" indicated the resident wandered into other residents' rooms and the behavior was not easily altered, on 08/06/14 at 8:52 p.m. and 9/11/14 at 3:49 p.m.</p> <p>The Interdisciplinary Progress Notes had indicated the resident had intrusively wandered into other residents' rooms on the following dates: 9/13/14--The resident wandered up and down the hallways and in and out of the residents' rooms. 9/15/14--The resident wandered up and down the hallways and into other residents' rooms</p> <p>The Interdisciplinary Progress Notes indicated the resident had resident to resident altercations. On 7/22/14 at 6 A.M., Resident #8 reported that Resident #66 hit and grabbed her left upper arm as he tried to</p>		<p>4. The DCS/Nurse Manager will conduct QI monitoring of the regulation F280 to ensure care plans are revised with appropriate interventions. QI monitoring will be conducted five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months using a sample size of five random residents. The DCS/Nurse Manager will report findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring,</p> <p>5. Date of Compliance: October 30, 2014</p>	

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  09/30/2014	
NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069			
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	<p>enter her room.</p> <p>On 7/24/14 at 5:30 P.M., Resident #66 walked into Resident #82's room where he and a family member were visiting with his dog. Resident #66 started to pet Resident #82's dog, then became agitated and cursed at the dog. Resident #66 picked up a pillow and threw it at Resident #82.</p> <p>On 8/19/14 at 7:20 A.M., Resident #66 was ambulating in the North hallway common area when he grabbed Resident #68's arm. Resident #68 raised his fist to Resident #66 and Resident #68 did the same back to him.</p> <p>The record, dated August 2014, indicated this resident was actively participating in "Snacks" 25 times, "Exercise" (Walks) 30 times, "Music, Radio and CD's" 30 times, "Falling Star" 17 times (11/17 times he wandered while in the activity) "Household Tasks" 10 times and "Starlight". He wandered 19 times while in the "Starlight" activity. He attended Ice cream social two times, a Birthday party one time, a pet visit activity one time and a religious activity one time. His record lacked documentation to indicate whether the resident was actively participating in these activities.</p>						

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>The record dated September 2014, indicated this resident was actively participating in "Snacks" 20 times, "Exercise" (walked) 24 times, "Music, Radio and CD's" 24 times, "TV, Movies and Videos" 24 times, "Household Tasks" 24 times, "Starlight" and "Falling Star" program 4 times. He wandered 16 times while in the activities. He went to an Entertainment/special event once, a church activity one time, and attended the Ice cream social one time, but his record lacked documentation to indicate whether the resident was actively participating in these activities.</p> <p>The resident's "Activity Participation Record" lacked documentation to indicate the resident was involved in gardening or outdoor activities, which were activities that were of interest to him on his care plan.</p> <p>During an interview on 9/30/14 at 11:10 A.M., the Activity Director indicated the "outdoor sits" and "placing flowers in dirt" activity fell under the "household tasks" activity. So that was where she documented those activities. She indicated she knew she had problems with the way the activities were documented and she needed to fix that problem. The Activity Director indicated Resident #66 did not actively participate</p>			

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>in any activity for more than 10 minutes before he wandered away or she had to remove him from an activity because he was taking other residents' things. She indicated he wandered into the main dining room during bingo and took the other residents' bingo chips. They did not want him in there during activities.</p> <p>The resident's Activities Care Plan lacked documentation that revisions were made to accommodate his activity preferences and interventions to prevent him from intrusively wandering into other residents' rooms, prevent resident to resident altercations and to prevent boredom.</p> <p>2. The record for resident # 57 was reviewed on 9/26/14 at 8:21 a.m. Current diagnoses included, but were not limited to, dementia with behavior disturbances and psychiatric disorder with delusions.</p> <p>A plan of care, dated 5/12/14 and updated 8/12/14, indicated the resident wandered into others' rooms, with approaches that included, but were not limited to, "redirect inappropriate behavior as needed." The goal indicated the resident would wander safely and be directed away from others' rooms daily. There was no date to indicate when approaches were added.</p>			

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>A psychiatric progress note, dated 6/20/14, indicated the resident wandered about and was "quick to anger! He will grab staff's arms/wrists &amp; [and] twist violently...."</p> <p>A 7/16/14 social service note indicated the resident wandered frequently throughout the night.</p> <p>Nurses notes indicated, on 8/20/14 at 9 p.m., the resident wandered up and down the halls and in and out of other resident rooms.</p> <p>During an interview on 09/25/2014 at 3:16 P.M., Resident # 8 indicated Resident #57 came into her room at night and once he tried to crawl into bed with her.</p> <p>During an interview on 09/25/2014 3:37 P.M., CNA #2 indicated some of the residents were annoyed and impatient when the residents wandered into their rooms and want them out of their room. He indicated Resident # 57 wandered.</p> <p>The Activity participation record for September 2014 indicated the resident actively participated in "starlight" daily and wandered during these activities for 23/25 days. The record indicated the resident attended ice cream once, church</p>			

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>once, entertainment once and one walk outside. He had and "A" every day in the box for exercise, music, radio, CD, TV, movie, video.</p> <p>August 2014 activity participation record indicated he participated in "starlight" daily with wandering and confusion for 19/30 days and actively participated 4/30 days. He participated in "household tasks" with wandering 15/30 days . He attended entertainment 5 times, Bible study once, ice cream once, and went outside 3 times.</p> <p>July 2014 activity participation record indicated he participated in "starlight" daily with wandering 25/30 days and "household tasks" with wandering 15/30 days. He attended ice cream 2 times, entertainment 3 times, birthday party, church 2 times, and movies once. He had one to one checked with no time indicated for 15/30 days.</p> <p>July, August and September 2014 records had an "A" in the exercise box indicating he walked, and was provided music, radio, CD, TV, movies videos.</p> <p>During an interview with the Activity Assistant on 09/29/2014 at 9:36 A.M., she indicated the resident liked big Legos and she would use them for his activities.</p>			

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	<p>She indicated he had no specific activity plan in place for his wandering.</p> <p>The record did not indicate the plan of care had been revised with appropriate interventions to assist the resident for activity participation to prevent intrusive wandering. There were no revised interventions to prevent wandering or ensure safe and un-intrusive wandering.</p> <p>3. The record for Resident # 33 was reviewed on 9/26/14 at 9:27 a.m. Current diagnoses included, but were not limited to, dementia with behavioral disturbances.</p> <p>A plan of care, dated 9/22/14, indicated the resident wandered about the facility and his behavior would escalate with redirection. There was no plan of care for wandering prior to 9/22/14.</p> <p>Nursing notes indicated that Resident #33, "7/5/14 wanders down the halls."</p> <p>A "Behavior Detail Report" indicated the resident wandered into other resident rooms on 4/4/14 and was not easily altered. The resident wandered in the hallways and common areas.</p> <p>During an interview on 09/25/2014 3:34 P.M., NA #1 indicated Resident #33</p>			

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069		
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	<p>intrusively wandered into other resident's rooms.</p> <p>During an interview on 09/25/2014 at 3:39 P.M., LPN #3 indicated other residents objected when Resident #33 intrusively wandered into their rooms.</p> <p>The record did not indicate the plan of care had been revised with effective interventions to assist the resident for activity participation to prevent intrusive wandering and there were no revised interventions to prevent wandering or ensure safe and un-intrusive wandering.</p> <p>A 6/17/14 activity progress note indicated his interests included but were not limited to, games, music, news, pets, religion and TV.</p> <p>A plan of care, dated 1/16/14 updated 9/9/14, indicated the resident wandered in and out of activities with a goal to stay in activities at least 20 minutes daily. Approaches included, but were not limited to, "encourage him to stay, call out name to keep his attention, bring to household task, starlight, church, ice cream, music, large Legos, and talk about family farm." There was no date on the interventions to indicate when they were added.</p>				

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>The Activity participation record for September 2014 indicated, the resident refused snacks, actively participated in exercise by propels, had wife visits, had music, radio or cd, movies or videos daily. He attended church 3 times, had 2 walks outside and attended a birthday party and had ice cream twice. The record indicated the resident attended "starlight" which was an evening program.</p> <p>August 2014 indicated the resident participated in "starlight" 27 days, "household tasks" 27/30 days, entertainment 5 times, ice cream 2 times, church 2 times, Bible study and a birthday party and participated in falling stars 13/30 days.</p> <p>July 2014 indicated the resident participated in "starlight" daily, "household tasks" daily, attended church 4 times, Bible study 2 times, ice cream one time, a birthday party and entertainment 3 times.</p> <p>The July and September activity participation record indicated he wandered in and out of the activity.</p> <p>During an interview with the activity assistant on 09/29/2014 at 9:36:49 A.M., she indicated the resident liked big</p>			

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	<p>Legos and she would use them for his activities. She indicated he wandered in and out of the activities and had no specific activity plan in place for his wandering.</p> <p>4. A policy titled "Behavior Monitoring" was provided by the RDCO on 9/26/14 at 9:30 a.m., and deemed as current. The policy indicated: "Policy Residents demonstrating behaviors that place a resident at risk, or interfere with care and other residents will be monitored and interventions initiated as an individualized approach to minimizing behavior...11. Interdisciplinary team will review behaviors, causative factors/triggers and or root cause to determine individualized interventions to minimize or eliminate targeted behaviors. 12. Resident's plans of care will be updated as needed."</p> <p>5. Resident #47's record was reviewed on 9/24/2014 at 5:20 P.M. Diagnoses included, but were not limited to, iron deficiency anemia, dementia, depressive disorder and macular degeneration.</p> <p>The resident's document, "Fall Risk Identification and Plan of Care", dated 8/22/13, indicated the resident was not consistently oriented to her own limitations. The back of the document, "Risk Identification Review" indicated</p>				

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F000282 SS=D	<p>the resident fell on 9/12/13 and 1/22/14 and that interventions were updated.</p> <p>The resident's, "Fall Investigation", dated 7/21/14, indicated the resident fell and sustained a facial hematoma. In addition, it indicated the resident's care plan was updated. The resident's record lacked an updated care plan.</p> <p>During an interview on 9/30/14 at 10:35 A.M., the Assistant Director of Clinical Services indicated she thought she had updated the care plan, but was unable to find the update revising the care plan that indicated the resident should not be left unattended.</p> <p>As of exit on 9/30/14 at 2:15 P.M., no other information was provided.</p> <p>3.1-35(d)(2)(B)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to follow the care plans for Range of Motion interventions for 1</p>	F000282	F-282 1. Resident # 20 will be screened by therapy services for	10/30/2014	

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>of 1 resident reviewed for Range of Motion (Resident #20) and failed to follow Physician orders for medications for 1 of 35 residents reviewed for Care Plans. (Residents #77)</p> <p>Findings include:</p> <p>1. Resident # 20's record was reviewed on 9/29/14 at 4:34 P.M. Diagnoses included, but were not limited to, end-stage dementia, left hand contracture and lack of coordination.</p> <p>The resident had a Care Plan, dated 4/6/11, that addressed the problem of a left hand contracture. Approaches included, but were not limited to, "2/24/11-Remove, wash, dry, PROM [passive range of motion] QD [every day]...."</p> <p>During an interview on 9/23/14 at 10:32 A.M., the Assistant Director of Clinical Services (ADCS) indicated the resident had a contracture of the left hand. She indicated she received range of motion (ROM) services through Restorative nursing therapy, but the ROM services were not done as scheduled because the facility had been short staffed on CNA's and had been using agency often. She indicated the Restorative CNA's were taken away from their Restorative</p>		<p>recommendations on appropriate range of motion (ROM) services. Resident # 77 no longer resides at the facility.</p> <p>2. All residents have the potential to be affected by this alleged deficient practice.</p> <p>In-house residents with limited range of motion, not currently on therapy caseload, will be screened by therapy services for recommendations on appropriate range of motions services. The Director of Clinical Services (DCS)/Nurse Manager will review laboratory tests ordered during the month of October for physician notification by October 24, 2014. Any issues identified will be corrected immediately.</p> <p>3. The DCS/ Nurse Manager re-educated the licensed nurses on reporting lab results and on the emergency drug kit (EDK) on October 9, 2014. The DCS/ Nurse Manager re-educated the licensed nurses The DCS/ Nurse Manager re-educated the nursing staff on providing restorative nursing services by October 28, 2014.</p> <p>4. The DCS/Nurse Manager will conduct QI monitoring of the regulation F282 to ensure care plans for ROM</p>	

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	<p>nursing job duties to cover as CNA's on the units providing resident care. So the ROM exercises were not being completed on the residents.</p> <p>On 9/23/14 at 1:51 P.M., Resident #20's left hand was observed to have a contracture with a palm protector in place.</p> <p>During an interview on 9/30/14 at 11:48 A.M., CNA #8 indicated she had to provide residents on the units resident care. She could not do her Restorative nursing duties because they were short staffed. She indicated she did not know what residents were on the Restorative nursing therapy caseload at this time. She indicated she had not been receiving the communication forms to indicate what residents were to receive Restorative nursing therapy after they were discharged from therapy.</p> <p>During an interview on 9/30/14 at 11:55 A.M., the ADCS indicated Resident #20 did not have any Restorative nursing therapy documentation to indicate that she had received Restorative nursing therapy after therapy had discharged her in August.</p> <p>2. The record for Resident # 77 was reviewed on 9/26/14 at 3:04 P.M., current diagnoses included, but were not limited</p>		<p>interventions and physician orders for medications are followed. QI monitoring will be conducted five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months using a sample size of five random residents. The DCS/Nurse Manager will report findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring,</p> <p>5. Date of Compliance: October 30, 2014</p>	

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  09/30/2014
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	<p>to, Infarct and anemia.</p> <p>Nursing notes, dated 8/15/14, indicated she had rectal bleeding with a foul odor, and abdominal pain with a temp 100.7. The note indicated she went to the Emergency room and returned with on order for an antibiotic for a Urinary Tract Infection (UTI).</p> <p>Physician's orders indicated the following was to be done: 9/3/14: UA C&amp;S (Urinalysis with Culture and Sensitivity) 9/10/14: Macrobid 100 milligrams every 12 hours for 7 days</p> <p>A Urinalysis, dated 9/6/14, indicated the resident had 2+ leukocytes (abnormal), few bacteria (abnormal) and had enterococcus faecalis in her urine with a culture and sensitivity completed. The lab indicated the physician was faxed the lab on 9/6/14. The lab was signed on 9/10/14 by the physician.</p> <p>A hospital physician history and physical, dated 9/22/14, indicated the resident was admitted to the hospital for sepsis secondary to a UTI.</p> <p>The September Medication Administration Record indicated the Macrobid 100 milligrams was not</p>			

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069			
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	<p>administered until 9/12/14 in the evening, which was a delay in administration.</p> <p>During an interview on 09/29/2014 10:20 A.M., additional information was requested from the DCS (Director of Clinical Services) related to the delay in administration of the antibiotic.</p> <p>During an interview on 09/29/2014 2:14 P.M., LPN #10 indicated the Macrobid was available in the EDK (Emergency Drug Kit). During an observation at this time, there were 6 tablets of the Macrobid 100 milligrams available for administration. She indicated if a medication was not available from pharmacy especially an antibiotic, she would check the EDK. She indicated an antibiotic should be given within 2 hours of the order.</p> <p>A Policy titled "Change in Resident Condition" was provided by the DCS on 9/29/14 at 1:15 P.M., and deemed as current. The policy indicated: "...Procedure...2. The Physician...will be notified as soon as possible include (sic) but not limited to significant change...change in treatment....All physician-ordered interventions will be immediately carried out by the Clinical Nurse...."</p>						

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 09/30/2014	
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F000312 SS=D	<p>3.1-35(g)(2)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review and interview, the facility failed to provide incontinence care to a resident that needed assistance for 1 of 1 resident reviewed for incontinence. (Resident E)</p> <p>Findings include:</p> <p>Resident E's record was reviewed on 9/26/14 at 3:07 P.M. Diagnoses included, but were not limited to constipation, diverticulosis, colitis and colostomy left quadrant.</p> <p>The resident had a Care Plan, dated 9/12/14, that addressed the problem she could not independently complete her Activities of Daily Living related to weakness. Approaches and Interventions included, but were not limited to, "...4) Assist with A.M. and P.M. care as needed."</p> <p>The resident had a Care Plan, dated 9/12/14, that addressed the problem she</p>	F000312	<p>F-312</p> <ol style="list-style-type: none"> <li>Resident E shows no apparent adverse affect from this alleged deficient practice.</li> <li>Incontinent residents have the potential to be affected by this alleged deficient practice.</li> <li>LPN # 4 is no longer works at the facility. The DCS/Nurse Manager will re-educate LPN #5 on providing incontinent resident care by October 28, 2014. The DCS/ Nurse Manager will re-educate the nursing staff on providing incontinent resident care by October 28, 2014.</li> <li>The DCS/Nurse Manager will conduct QI monitoring of the regulation F312 to ensure incontinence care is provided to residents when needed. QI monitoring will be conducted across all three shifts through observation and/or resident interview five times a week for four weeks, three times a week for four weeks, weekly</li> </ol>	10/30/2014			

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  09/30/2014
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	<p>had a colostomy.</p> <p>The resident had a Care Plan, dated 9/3/14, that addressed ADL Functional/Rehab Potential: Toileting with assist of 1</p> <p>On 9/25/14 at 9:31 A.M., Resident E indicated to LPN #5 that she needed help because she "can smell myself down there." The resident was observed pointing to her abdomen and perineum area. She indicated that someone had come into her room earlier and told her they would be back to take care of her, but that person never came back. At that time CNA #9, who was responsible for the resident's care, stepped into the room and the CNA indicated she would return to take care of the resident after she finished what she was doing.</p> <p>During a medication administration observation on 9/25/14 at 9:42 A.M., Resident E indicated to LPN #4 she needed help down there while she pointed to her abdomen and perineum area. She indicated she "can smell myself down there." The resident asked LPN #4 when someone was going to help her. LPN # 4 indicated her CNA would be with her shortly. She indicated the CNA was assisting another resident at this time and then she left the room.</p>		<p>for four weeks, then monthly for three months alternating shifts using a sample size of five random residents. The DCS/Nurse Manager will report findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring,</p> <p>5. Date of Compliance: October 30, 2014</p>	

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  09/30/2014
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	<p>During an interview on 9/25/14 at 10:00 A.M., Resident E indicated she had a colostomy that needed emptied and she had been incontinent of urine into her brief. She indicated she could smell herself and she needed her brief changed.</p> <p>On 9/25/14 at 10:08 A.M., LPN #4 was observed to administer the resident's nebulizer treatment. CNA #9 came into the room at this time to assist the resident with care and LPN #4 indicated she was administering her nebulizer treatment and she would be finished shortly. CNA #9 left the room.</p> <p>On 9/25/14 at 10:15 A.M., CNA #9 came into the Resident E's room. She indicated the resident had a catheter. She was observed looking on both sides of the bed. She indicated the last time she gave personal care to this resident she had a catheter, but no one had indicated to her the resident no longer had a catheter.</p> <p>During an interview on 9/26/14 at 1:10 P.M., the Director of Clinical Services indicated he expected the residents to get the assistance they requested. He indicated if a staff member was an appropriately licensed staff member, then he would expect the staff member to provide incontinent care for the resident.</p>			

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F000314 SS=D	<p>He indicated he expected residents to receive assistance after an incontinent episode as soon as possible. He indicated, if a licensed staff member entered a resident's room and did not have an emergency occurring at that time, he would expect the staff member to assist the resident right away. He indicated he would not want to put a time limit on how long was too long for a resident to wait for help. It was dependent on the situation, there may be times when staff were busy.</p> <p>This Federal Tag relates to Complaint IN00155737</p> <p>3.1-38(a)(3)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to</p>	F000314	<p>F-314</p> <p>1. Residents # 26 and 49 preventative interventions in place.</p>	10/30/2014	

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	<p>provide effective interventions and timely identification to prevent facility acquired pressure ulcers for 2 of 3 residents reviewed for pressure ulcers. (Residents #49 and #26) Resident #49's pressure ulcer to the right inner buttock was first identified on 7/10/14 as an unstageable ulcer.</p> <p>Findings include:</p> <p>1. Resident # 49's record was reviewed on 9/29/14 at 10:16 A.M. Diagnoses included, but were not limited to, chronic ischemic heart disease, congestive heart failure with left ventricular dysfunction, diabetes mellitus insulin dependent, depression, and vascular dementia.</p> <p>The resident had a Care Plan, dated 3/3/14, that addressed the problem he had a Braden scale of 19, which was an increased risk for developing pressure ulcers related to a history of sitting in one position for extended periods of time. Approaches included, but were not limited to, "3/3/14-Skin sweep weekly, Monitor skin q [every] shower... 7/17/14-Roho cushion in recliner chair."</p> <p>The resident's Physician orders recap (Recapitulation), dated September 2014, included, but were not limited to the following orders:</p>		<p>2. Residents at risk for skin breakdown have the potential to be affected by this alleged deficient practice. In-house residents will be re-assessed for their risk for skin breakdown and those identified, as at risk, will be reviewed by the DCS/Nurse Manager for appropriate prevention interventions by October 28, 2014.</p> <p>3. The DCS/Nurse Manager will re-educate the nursing staff on pressure ulcer prevention and interventions by October 28, 2014. Residents will receive a weekly skin assessment by a licensed nurse.</p> <p>4. The DCS/Nurse Manager will conduct QI monitoring of the regulation F314 to ensure effective interventions and timely identification to prevent facility acquired pressure ulcers. QI monitoring will be conducted through observation and/or record review five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months using a sample size of five random residents. The DCS/Nurse Manager will report findings to two quarterly QAPI committee</p>				

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	<p>On 7/16/14, a Roho cushion was ordered in the recliner at all times related to a Stage IV wound on his right inner buttocks.</p> <p>On 9/19/14, an order was written to discontinue the previous treatment orders to his bilateral buttocks and start Duoderm dressing to his left and right inner buttocks. The dressing was to be changed twice weekly on his shower days and as needed. The wound was to be cleansed prior to applying the dressing.</p> <p>On 8/12/14, an order for bedrest was written and discontinued on 9/24/14.</p> <p>On 9/24/14, an order for up ad lib was written.</p> <p>The resident's Annual Minimum Data Set assessment, dated 7/18/14, indicated he was moderately cognitively impaired. The resident's functional status indicated he was extensive assist with one person physical assist for bed mobility and transfers. He was at high risk for developing pressure ulcers. He had a Stage IV pressure ulcer with eschar present.</p> <p>The resident's Braden scale on 8/19/14 was 13, which indicated he was at moderate risk of developing a pressure ulcer. The resident's Braden scale on 8/26/14 was 17, which indicated he was at a high risk of developing pressure</p>		<p>meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring,</p> <p>5. Date of Compliance: October 30, 2014</p>	

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	<p>ulcers.</p> <p>A "Weekly Nursing Progress Note," dated 7/9/14, indicated in the skin section there were no skin issues in the last seven days.</p> <p>A "Pressure Skin Condition Record", dated 7/10/14, indicated the resident had an open area to his right inner buttock that was facility acquired and refused to allow the ulcer to be measured. The drainage was a small/medium amount of a serous colored fluid. The periwound was reddened. There was no Stage documented.</p> <p>An Interdisciplinary Progress Note, dated 7/16/14 at 12 P.M., indicated the resident had a new order for a Roho cushion for his recliner.</p> <p>A "Pressure Skin Condition Record", dated 7/16/14, indicated a new order on 7/16/14 and he had a Stage IV to his right inner Buttock. There was no assessment completed on the wound.</p> <p>An Interdisciplinary Progress Note, dated 7/16/14 at 2 P.M., indicated the resident refused to go to the Wound Clinic for treatment to the pressure ulcer to his right inner buttock.</p>			

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	<p>A "Pressure Ulcer Record," dated 7/23/14, indicated the resident had a UTD (unable to determine the stage) pressure ulcer to the right inner buttock that was facility acquired and measured 3.2 x 2.1 x 0.2 cm (centimeters). The wound bed tissue type was slough (yellow or white stringy like tissue) and eschar (Black or brown dead tissue) with reddened wound edges. There was a small amount of serosanguineous drainage and the periwound was reddened.</p> <p>An Interdisciplinary Progress Note, dated 7/25/14 at 1:30 P.M., a Weekly Care Review note indicated the resident had a pressure ulcer on the right inner buttock, which developed from skin on skin pressure. The ulcer measured 3.2 x 2.1 x 0.2 centimeters and was full of slough. The ulcer was staged as an unstageable.</p> <p>A "Pressure Ulcer Record", dated 8/8/14, indicated the resident had a Stage III pressure ulcer to his right inner buttock that was facility acquired and measured 5.0 x 3.8 cm. The wound bed tissue type was slough and granulation (healthy tissue). The wound edges and periwound were reddened. There was a small amount of serous drainage.</p> <p>A Resident Transfer Form titled</p>			

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	<p>"Interact", dated 8/09/14, indicated when the resident was sent to the hospital he was sent to the hospital with three pressure ulcers and he was a high risk for developing pressure ulcers.</p> <p>He had a Stage III to the left inner buttock with red granulated tissue</p> <p>He had a Stage III to the right upper buttock with red granulated tissue</p> <p>He had a UTD (Unable to Determine the Stage) to the inner right buttock with slough tissue.</p> <p>A "Pressure Ulcer Record", dated 9/24/14, indicated the resident had a Stage II pressure ulcer to his right inner buttock that was facility acquired and measured 2.6 x 0.6 x 0.0 cm. The wound edges was epithelial tissue (healthy tissue). The wound edges and periwound was reddened. There was no drainage.</p> <p>An Interdisciplinary Progress Note, dated 8/8/14 at 11 A.M., indicated a skin sweep was completed. The treatment to the right inner buttock was completed and a Stage III pressure ulcer was noted to the right upper buttock.</p> <p>An Interdisciplinary Progress Note, dated 8/4/14 at 11 P.M., indicated the right buttocks wound measured 2.0 x 0.2 x 0.1 cm.</p>			

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	<p>A "Pressure Ulcer Record", dated 8/8/14, indicated the resident had a pressure ulcer to the right upper buttock that was a Stage III that was facility acquired and measured 3.8 x 3.0 x 0.3 cm. The wound tissue type was granulation. The wound edges and periwound was reddened. There was no drainage.</p> <p>A "Weekly Nursing Progress Notes", dated 8/13/14, indicated the skin section indicated the resident had an area on his right buttock that measured 2.6 x 2.6 cm.</p> <p>A "Pressure Ulcer Record", dated 9/3/14, indicated the right upper buttock pressure ulcer was healed.</p> <p>An Interdisciplinary Progress Note, dated 8/4/14 at 11 P.M., indicated the left buttocks wound measured 4.0 x 2.0 x 0.1 cm. The note indicated the resident's left buttock wound appeared worse.</p> <p>An Interdisciplinary Progress Note, dated 8/8/14 at 11 A.M., indicated a skin sweep was completed. The treatment to the right inner buttock was completed and then a Stage III ulcer to the left inner buttocks was discovered.</p> <p>There was no documentation on a "Pressure Ulcer Record", dated 8/8/14, for the left inner buttocks. All the</p>			

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	<p>resident's pressure ulcer documentation was requested from the Director of Clinical Services on 9/29/14 at 1:00 P.M.</p> <p>An Interdisciplinary Progress Note, dated 8/20/14 at 1 P.M., indicated the Weekly Care Review indicated the resident had three Stage III pressure ulcers located to the left and right inner buttocks and the right upper buttock.</p> <p>A "Pressure Ulcer Record", dated 9/19/14, indicated the resident had a Stage II pressure ulcer to his left inner buttocks that was facility acquired and measured 3.2 x 3.4 x 0.2 cm. The wound type was epithelial and granulation tissue. The wound edges and periwound were reddened. There was a small amount of serosanguineous drainage.</p> <p>A "Pressure Ulcer Record", dated 9/24/14, indicated the resident had a Stage II pressure ulcer to his left inner buttocks that was facility acquired and measured 1.2 x 0.8 x 0.2 cm. The wound type was epithelial and granulation tissue. The wound edges and periwound were reddened. There was a small amount of serosanguineous drainage.</p> <p>Review of the Interdisciplinary Progress Notes, from 7/10/14 to 9/24/14, indicated the resident refused to go to bed at times,</p>			

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	<p>sat on the toilet for over an hour at times, refused showers, refused to lay down, refused personal hygiene after an incontinent episode and refused treatments to his pressure ulcers at times. Staff would educate the resident on the risks of refusals of care.</p> <p>On 9/29/14 at 2:10 P.M., the resident indicated he had his shower earlier this morning instead of this evening and the nurse applied the dressing to his wounds.</p> <p>During an interview on 9/23/14 at 1:54 P.M., the Assistant Director of Clinical Services (ADCS) indicated the resident had a Stage II pressure on his left inner buttock that measured 3.2 x 3.4 x 0.2 cm and he had a Stage II to his right inner buttock that measured 3.0 x 1.2 x 0.2 cm. She indicated both pressure ulcers were facility acquired.</p> <p>During an interview on 9/30/14 at 9:18 A.M., the ADCS indicated the CNA's did not document the resident's showers on shower sheets. She indicated the nurses document skin assessments on the "Weekly Nursing Progress Notes" once a week. The resident's skin assessment sheets from 6/1/14 to present date were requested at this time. The ADSC indicated she did do measurements of the resident's pressure ulcer to the right inner</p>			

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	<p>buttocks on 7/11/14 when she assessed the wound. She did not know where those measurements could be located. There were no measurements on the wound sheet for the right inner buttock pressure wound for 7/11/14 or 7/16/14.</p> <p>During an interview on 9/30/14 at 9:25 A.M., the Regional Director of Clinical Services (RDCS) indicated the "Weekly Nursing Progress Notes" indicated the nurses were documenting a summary of what had occurred in the skin section on that form over the last seven days. She indicated the nurses were documenting a summary and the nurses had not actually looked at the resident's skin on that particular day that they wrote that summary because they used other tools to write the summary so that was why on 7/9/14 the "Weekly Nursing Progress Notes" indicated no skin issues and the next day an unstageable pressure ulcer was found on resident's right inner buttock.</p> <p>At that time the Director of Clinical Services indicated the resident had not refused any dressing changes prior to the two Stage III pressure ulcers being found on 8/8/14 after he reviewed the Treatment Administration Record. He indicated the interventions that were in place to prevent the resident from</p>			

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>developing a pressure ulcer was a Roho cushion that was put into place on 7/17/14. He indicated the Roho cushion was put into place after the pressure ulcer developed and the resident had some interventions on his Braden Care Plan that were implemented before he developed the pressure ulcer.</p> <p>No documentation was found that indicated the resident had a pressure relieving device in his recliner prior to the development of the right inner buttocks pressure ulcer on 7/10/14.</p> <p>No documentation was found to indicate the resident had a pressure relieving device in his recliner after the development of the pressure ulcer until 7/16/14.</p> <p>At the end of the exit conference on 9/30/14 at 2:15 P.M., there was no further information given regarding the resident's skin assessment's or interventions that were in place prior to the resident developing the facility acquired pressure ulcers.</p> <p>2. The record for Resident #26 was reviewed on 9/26/14 at 1:58 P.M. Diagnoses included, but were not limited to, dementia, osteoarthritis, scoliosis, muscle rigidity, and senile depression.</p>			

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	<p>The resident's Physician orders recap (Recapitulation), dated September 2014, included, but were not limited to, the following orders: 12/4/13--Elevate legs as much as possible 9/22/14--Skin prep to bilateral heels every shift. 9/22/14--Prevalon boots on to offload feet from bed-remove for skin care every shift and reapply.</p> <p>The resident had a Care Plan, dated 1/9/14, that addressed the problem Braden Scale was 13, which placed the resident at risk for developing pressure ulcers.</p> <p>Approaches included, but were not limited to, "1/9/14--skin sweep q week... Assist reposition q [every] w+[and] 2 PRN [as needed], Antidecubic WC [wheelchair], Antidecubic mattress...."</p> <p>The resident's Quarterly Minimum Data Set assessment, dated 6/7/14, indicated: Cognitive Skills for Daily Decision Making were Moderately Impaired. The resident's functional status for bed mobility and transfers were extensive assist with one person physical assist.</p> <p>The "Pressure Ulcer Record", dated 9/19/14, indicated the resident developed</p>			

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069			
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	<p>a blister that was an UTD (Unable to determine the stage) pressure ulcer that was facility acquired to her left heel. The ulcer measured 2.0 x 2.0 x 0.0 cm. The tissue type was a blister. The color was red with no drainage. The wound edges were firm.</p> <p>The "Pressure Ulcer Record", dated 9/23/14, indicated the resident developed a DTI (deep tissue injury) that was facility acquired to her left heel. The ulcer measured 2.4 x 2.3 x 0.0 cm. The wound bed was described as epithelial and an area that was a closed serum filled blister. The wound edges were firm. There was no drainage.</p> <p>The resident's record lacked documentation her bilateral feet were being elevated on a routine basis prior to the development of the Stage II to the left heel on 9/19/14.</p> <p>On 9/26/14 at 12:50 P.M., the resident's left heel pressure ulcer was observed as a wine colored area with firm edges. The resident had her Prevalon boots in place to her bilateral feet. .</p> <p>During an interview on 9/23/14 at 10:38 A.M., the Assistant Director of Clinical Services indicated the resident had an unable to determine the stage pressure</p>						

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>ulcer to her left heel that was facility acquired that measured 2.0 x 2.0 x 0.0. She indicated the wound was found on 9/19/14 as a blister and the color was red.</p> <p>During an interview on 9/26/14 at 12:50 P.M., LPN # 11 indicated that, before the resident's health declined recently, she would sit in her recliner and her feet would be on the footrest of the recliner. She indicated at times the resident's heels would be elevated on pillows while sitting in the recliner and at times they would not be elevated on pillows.</p> <p>During in interview on 9/30/14 at 9:45 A.M., the Assistant Director of Clinical Services indicated she did not know the cause of the pressure ulcer to the resident's left heel. She indicated the resident sat in her recliner and she did not have her heels propped up with pillows on a routine basis. She indicated she did not find documentation in the resident's record that indicated staff had documented the resident's heels were propped on pillows on a routine basis and she did not find an intervention or an order that the resident was to have her heels propped while in bed or sitting up in the recliner.</p> <p>3. A current policy titled "Skin Assessment-Weekly" dated 02/06/14,</p>			

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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F000315 SS=D	<p>provided by the Director of Clinical Services on 9/30/14 at 9:30 A.M., indicated "Policy: A Licensed Nurse will complete a total body assessment on each resident weekly, paying particular attention to any skin tears, bruises, stasis ulcers, rashes, pressure ulcers, lesions, abrasions, reddened areas and skin turgor problems. The purpose of the Skin Assessment is to evaluate the condition the resident's skin on a regular basis. As the nursing assistants are the resident's primary care giver, Licensed Nurses to regularly assess each resident's skin condition, but also provides a means of evaluating the nursing assistant's reporting of and response to residents with skin problems. Procedures: 1. A Licensed Nurse will complete a total body assessment on each resident weekly and document the assessment on the "Weekly Skin Integrity Review" form...."</p> <p>3.1-40(a)(1)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates</p>			

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	<p>that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview, and record review, the facility failed to provide coordination of care related to urinary incontinence and to prevent urinary tract infections for 2 of 2 residents reviewed for urinary incontinence in a sample of 2. (Residents C &amp; D)</p> <p>Findings include:</p> <p>1. On 9/25/14 at 3:30 p.m., the record review for Resident D was completed. Diagnoses included, but were not limited to, Diabetes, urinary tract infections (UTI), arthritis and chronic cystitis (inflammation of bladder).</p> <p>The resident had a urine cultures obtained on the following dates due to possible urinary tract infections (UTI's): "...11/24/13-the organisms were E-Coli and Proteus Mirabilis. 1/31/14- the organism was E-Coli. 3/23/14-indicated mixed path, probable contamination. 4/2/14- new culture from 3/23/14 contamination, indicated organism pseudomonas aeruginosa.</p>	F000315	<p>F-315</p> <p>1. Resident D completed antibiotic as ordered by physician and is followed by the urologist on an as needed basis. Resident C shows no apparent adverse affect and has urological appointments scheduled for 10/16/14 and 11/06/14.</p> <p>2. All residents have the potential to be affected by this alleged deficient practice.</p> <p>3. The DCS/ Nurse Manager will re-educate the licensed nurses on the facility's intermittent catheterization policy by October 28, 2014. The DCS/ Nurse Manager will re-educate LPN # 11 on intermittent catheterizations by October 28, 2014. The Central Supply Clerk will coordinate resident doctor's appointments and notify licensed nurses of the arrangements. Resident doctor's appointments and transportation arrangements will be maintained on a calendar.</p> <p>4. The DCS/Nurse Manager will conduct QI monitoring of the regulation F315 to ensure coordination of care related</p>	10/30/2014

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  09/30/2014	
NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069			
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	<p>5/5/14- Indicated E-Coli and probable non-hem strep no sensitivity was done. Ordered Cipro (an antibiotic) 500 milligrams by mouth twice daily for 7 days...."</p> <p>The physician's orders indicated: "...2/14/14- Continue Urecholine (medication to treat bladder problems) in and out catheterization (placement of a tube into urethra and into bladder to empty urine) two times daily and record. Please bring record of most recent volume on next visit. 3/11/14- indicated the resident received Keflex (antibiotic) 500 milligrams TID (three times daily) for 7 days. 4/5/14- the resident received Cipro (antibiotic) 250 milligrams by mouth twice daily for 7 days. 5/5/14- Urostat 30 milliliters by mouth twice daily and Cipro 500 milligrams by mouth twice daily for 7 days for a UTI. In and out catheterization daily record residual (5/6/14) Resident to follow up with [name of urologist] (5/13/14) 9/8/14- Keflex 500 milligrams by mouth TID for 7 days...."</p> <p>A urologist report, dated 5/28/14, indicated: "...assessment : urge incontinence, 3 month follow up of Urge Urinary Incontinence. Ditropan</p>		<p>to urinary incontinence and prevent urinary tract infections. QI monitoring will be conducted across all three shifts through observation and/or record review five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months alternating shifts using a sample size of three random residents. The DCS/Nurse Manager will report findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring,</p> <p>5. Date of Compliance: October 30, 2014</p>				

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  09/30/2014
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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>[medication to relieve urinary and bladder difficulties] had been stopped. Urecholine 25 milligrams started and in and out cath at least twice daily initiated. Patient here alone for follow up, she can't tell me if she is better or not. She doesn't remember how often she gets catheterized, doesn't remember if she was catheterized this morning-doesn't recall last UTI. Notes from Extended Care Facility only contain medication list no information about cath schedule. I'll recommend no changes at this time unless I hear of new problems. She is to schedule a follow up visit as needed...."</p> <p>On 9/26/14 at 10 a.m., an observation was made of Resident D having an in and out catheterization performed by LPN #11. LPN # 11 went to the sink in the bathroom and washed her hands for 20 seconds. Then LPN # 11 touched the bedside table and blinds, bedcover, and had to go into another room to get a pair of gloves. She put the gloves on, without washing her hands again. She then pulled down the resident's brief, removed her gloves, and then washed her hands. LPN # 11 then took the sterile catheter kit, and unwrapped it. She placed her sterile field on top of the resident's belly, put on the sterile gloves, and then touched the top of the brief with her right gloved</p>			
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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>hand, and pulled it down more. After she touched the brief with her right gloved hand, LPN #11 then used betadine swabs with her right hand to cleanse the resident's labia. LPN #11 then took the right gloved hand and picked up the catheter and slid it in and out of the urinary meatus a few times and did not get any residual. She and the resident both indicated that was unusual. At that time, during interview, LPN #11 indicated the resident had just been toileted.</p> <p>On 9/26/14 at 10:20 a.m., the Regional Director of Clinical Services indicated the sterile field should be maintained during in and out catheterization.</p> <p>2. On 9/24/14 at 10:45 a.m., the record review for Resident C was completed. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease, depression, morbid obesity, urinary incontinence and insomnia.</p> <p>On 9/23/2014 2:30 p.m., a urine odor was noted when sitting near resident's bed.</p> <p>Prior Facility nursing notes, dated 7/17/14, indicated, "... resident was to have a [sic] schedule up [sic] appointment for urologist...7/1/14- Resident spoke with resident this date</p>			

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>regarding recent verbal outbursts. Resident expressed frustration with bladder which at times she reports, causes incontinence...."</p> <p>The care plan, dated 8/14/14, indicated, "...Bladder a lot of trouble- spasticity, UTI's, Diuretics daily, Psychoactive meds...Urologist (name)...Approaches and interventions Myrbetriq [a medication for overactive bladder]...8/18/14- Bactrim [an antibiotic] twice daily for 7 days, 8/28/14 Urinalysis with culture and sensitivity 8/31/14- Macrobid [an antibiotic] 100 milligrams twice daily for 7 days.... "</p> <p>There was no documentation found regarding follow up with a urologist.</p> <p>On 9/25/14 at 2:30 p.m., the Central Supply Coordinator indicated that she was the one who coordinated doctor's appointments for the nursing staff. She indicated Resident C had an appointment scheduled next week to go to the urologist. She indicated if there were specific issues going on, nursing would have to follow up with doctor's office.</p> <p>On 9/29/14 at 9:10 a.m., the Director of Clinical Services indicated the nursing staff were responsible for coordination of information after a resident's return from</p>			

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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F000318 SS=D	<p>an appointment from the urologist.</p> <p>This Federal Tag relates to Complaint IN00155737</p> <p>3.1-41(a)(2)</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, interview and record review, the facility failed to provide range of motion (ROM) services for a resident to prevent further decrease in ROM for 1 of 2 resident reviewed for range of motion services. (Resident #20)</p> <p>Findings include:</p> <p>The resident's record was reviewed on 9/29/14 at 4:34 P.M. Diagnoses included, but were not limited to, end-stage dementia, left hand contracture and lack of coordination.</p> <p>The resident had a Care Plan, dated 4/6/11, that addressed the problem of a left hand contracture. Approaches</p>	F000318	<p>F-318</p> <ol style="list-style-type: none"> <li>1. Resident # 20 will be screened by therapy services for recommendations on appropriate range of motion (ROM) services.</li> <li>2. Residents with limited ROM have the potential to be affected by this alleged deficient practice. In-house residents with limited range of motion, not currently on therapy caseload, will be screened by therapy services for recommendations on appropriate range of motions services October 28, 2014.</li> <li>3. The DCS/ Nurse Manager re-educated the licensed nurses The DCS/ Nurse Manager re-educated the nursing staff on providing restorative nursing services by October 28, 2014.</li> </ol>	10/30/2014

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 09/30/2014	
NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069			
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	<p>included, but were not limited to, "2/24/11-Remove, wash, dry, [sic] PROM [passive range of motion] QD [every day]...."</p> <p>The resident's Quarterly Minimum Data Set assessment, dated 8/14/14, indicated her Functional Limitation in Range of Motion for her upper and lower extremities had impairments on both sides.</p> <p>During an interview on 9/23/14 at 10:32 A.M., the Assistant Director of Clinical Services (ADCS) indicated the resident had a contracture of the left hand. She indicated she received range of motion (ROM) services through Restorative nursing therapy, but the ROM services was not done as scheduled because the facility had been short staffed on CNA's and using agency often. She indicated the Restorative CNA's were taken away from their Restorative nursing job duties to cover as CNA's on the units providing resident care, so the ROM exercises were not being completed on the residents.</p> <p>On 9/23/14 at 1:51 P.M., Resident #20's left hand was observed to have a contracture with a palm protector in place.</p> <p>During an interview on 9/30/14 at 9:18</p>		<p>4. The DCS/Nurse Manager will conduct QI monitoring of the regulation F318 to ensure ROM services are provided as indicated. QI monitoring will be conducted five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months using a sample size of five random residents. The DCS/Nurse Manager will report findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring,</p> <p>5. Date of Compliance: October 30, 2014</p>				

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	<p>A.M., the ADCS indicated the Therapy department did not write the orders for the Restorative nursing therapy after therapy was finished. She indicated therapy completed a communication form and gave it to the Restorative nursing CNA then she treated the residents after she received the communication form.</p> <p>During an interview on 9/30/14 at 10:52 A.M., PT (Physical Therapist) #7 indicated the resident was to be on Restorative nursing therapy for PROM for bilateral upper and lower extremity ROM.</p> <p>During an interview on 9/30/14 at 11:48 A.M., CNA #8 indicated she had to provide residents on the units resident care. She could not do her Restorative nursing duties because they were short staffed. She indicated she did not know what residents were on the Restorative nursing therapy caseload at this time. She indicated she had not been receiving the communication forms to indicate what residents were to receive Restorative nursing therapy after they were discharged from therapy.</p> <p>During an interview on 9/30/14 at 11:55 A.M., the ADCS indicated Resident #20 did not have any Restorative nursing therapy documentation to indicate that</p>						

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  09/30/2014
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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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F000323 SS=K	<p>she had received Restorative nursing therapy after therapy had discharged her in August.</p> <p>3.1-42(a)(2)</p> <p>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.</p> <p>A. Based on record review, and interview the facility failed to ensure residents with dementia who had a history of physical abuse, verbal abuse and intrusive wandering were supervised and interventions implemented to reduce the risk of harm to the residents or other residents for 3 of 3 residents reviewed for intrusive wandering. (Resident # 66, # 57 and # 33). Resident # 66 intrusively wandered into Resident 8's room, hit and grabbed her and into Resident # 82's room and threw a pillow at him. Resident # 8, #19, # 5 and # 88 indicated they were afraid of the residents that wandered into their rooms.</p> <p>An Immediate Jeopardy was identified on</p>	F000323	<p>F- 323</p> <p>1. Resident # 66 and 57 no longer reside in the facility. Resident # 33 was placed on 1:1 supervision until discharged to the hospital on 9/27/14. Resident #33 returned, status post hospital stay and medication adjustment. Resident currently on increased supervision.</p> <p>Residents # 5, 8, 19, 82, and 88 show no apparent adverse affects and will be seen by Social Services for psychological/ well being follow up by October 28, 2014.</p> <p>The IDT will review the care plan, nurse tech kardex and physician's orders for resident #47 by 10/24/14 to ensure fall preventative interventions are in place.</p>	10/30/2014

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 09/30/2014	
NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069			
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	<p>9/25/14 at 4:50 p.m. The Immediate Jeopardy began on 7/22/14 when Resident # 66 wandered into Resident # 8's room, hit and grabbed her. During interviews with Resident #8, #19, #5 and #88, they indicated they were fearful of the residents who wandered into their rooms. The Administrator, Regional Director of Clinical Operations and the Director of Clinical Services (DCS) were notified of the Immediate Jeopardy on 9/25/14 at 5:20 p.m. The immediate jeopardy was removed on 9/26/14, but noncompliance remained at the lower scope and severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy.</p> <p>B. Based on record review, observation and interview the facility failed to ensure fall interventions and investigations for root cause were completed and implemented to prevent further fall for 2 of 3 residents reviewed for accidents in a sample of 3. Resident # 66 sustained a head injury and 5 staples to his head after he had a fall when he was not being supervised by staff as his plan of care indicated. (Resident #66 and # 47)</p> <p>Findings include:</p> <p>A1. Resident # 66's record was reviewed</p>		<p>2. All residents have the potential to be affected by this alleged deficient practice. Current residents with a BIMS score greater than or equal to 8 were interviewed and asked:</p> <p>a. Has anyone mistreated you since you have been a resident here?</p> <p>b. Has anyone threatened you since you have been a resident here?</p> <p>c. Are you fearful of anyone here?</p> <p>Any negative responses were further investigated by the ED/DCS/ADCS/ Social Services Director. Any residents determined to have behaviors to include but not limited to intrusive wandering were discussed at the Behavior Management meeting on 9/25/2014 to ensure follow up on targeted behavior with appropriate interventions in place and care planned. Residents with a BIMS score less than 8 were assessed by licensed nurses via skin sweeps for suspicious injuries on 9-25-14 and no suspicious injuries were noted. Family council meeting was held on 9-25-14. Those in attendance were asked, "Any concerns about wandering residents?" No concerns were identified.</p>				

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>on 9/24/14 at 11:09 A.M. Diagnoses included, but were not limited to, dementia with behavior disturbances, difficulty in walking, altered mental status, lack of coordination, cognitive communicate deficit, psychological disease with hallucination other disease, late onset dementia, consider frontal lobe syndrome now with mood lability, impulsivity and behavior disturbances, anxiety and depression related to illness, and chronic insomnia.</p> <p>The resident was readmitted to the facility after an admission at a Geriatric Psychiatric Hospitalization in March 2014.</p> <p>A document titled "Psychiatric Evaluation", dated 2/11/14, indicated "...He has been wandering into other peers' rooms, he has been very focused on exploring the area at [name of facility] but, he is difficult to redirect and has created some increased anxiety amongst female peers because of his wanderings...The wandering is not going to respond to medication so providing a safe environment for him to wander would be likely an important piece of the environmental control. Unfortunately, when he wanders into peers' rooms that leads to increased peer-peer interaction and conflict."</p>		<p>Residents utilizing bed and/or chair alarms had the battery replaced in the alarm box on 9/23/14.</p> <p>The care plan, Nurse Tech Kardex, and physician's orders for residents who had fallen in the last 30 days were reviewed by the Falls Committee on 10/08/14 to ensure appropriate fall interventions were in place. Any issues identified were corrected immediately.</p> <p>3. On 9-25-14, the Regional Director of Clinical Services re-educated the Interdisciplinary team (IDT) including the Executive Director, Director of Clinical Services, Social Services Director, Activities Director, Assistant Director of Clinical Services and Minimum Data Set (MDS) Coordinator on the Behavior Management, Behavior Monitoring, Accident and Incident Reporting and Investigating, and Abuse Reporting and the Investigation Process.</p> <p>On 9-25-14, the RDCS re-educated the ED, DCS, ADCS and Social Services Director that the facility is to report any allegations of abuse resulting from behaviors to the State of Indiana within 24 hours to be</p>	

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069			
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	<p>A document titled "Psychiatry Progress Note and Treatment Summary", dated 7/24/14, indicated "Asked to see emergently, with more anger, aggression and quite agitated...Quick to anger...Poor Judgement...Progressive decline with intense anger/aggression now...Medications: 1. Arrow Up [Increased] Depakote Sprinkles to 250 mg Q [every] A.M. &amp; 375 mg Q 1700 [5 P.M.] 2. Resume Risperdal 0.25 mg Q 1700 [5 P.M.] (delusions/aggression) 3. Cont [continue] Klonopin 0.25 mg Q 1700 [5 P.M.] 4. Now Zoloft 75 mg Q A.M. (Recent Increase). He remains impulsive &amp; lacks safety awareness. May be better on a secured dementia unit."</p> <p>The resident had a Care Plan, dated 8/12/13, that addressed the problem of resident sensitive to care, resistive to care, poor safety awareness and impulse control, cursed at staff, hit and kicked staff, wandered, refused care and attempted to take other residents food.</p> <p>Approaches included, but were not limited to, "8/10/13--Resident without touching, call the resident by name, tell him to stop, be kind but firm...Ensure safety, re-approach, Change caregiver...1/14/14--Redirect with act</p>		<p>followed by a 5 day investigative summary, accordingly.</p> <p>On 9-25-14, the Director of Clinical Services (DCS)/Assistant Director of Clinical Services (ADCS) initiated education for facility staff to intervene and report behaviors to their supervisor for documentation in the medical record, behavior monitoring sheet and 24 hour report, along with updating of the care plan and any required follow up by the IDT-to include but not be limited to reporting to the State of Indiana within 24 hours and completing a 5 day investigation.</p> <p>On October 7, 2014 the RDSC re-educated the Activities Director on the regulation F 248 and the facility's policies on: Activity Program, Activity Assessment, Activity Care Plan, Conducting Activities, Participation in Activities, Safety and Supervision of Residents, Supplies and Equipment, and Progress Notes. The Activities Director received education from an outside consultant on October 17th and 22nd, 2014 on the regulation F 248, Behavior Management Intervention and Care Development. The outside consulting company will provide ongoing consulting monthly for six months.</p> <p>On 10-08-14 the RDSC re-educated the IDT on the facility's Falls</p>				

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>when wandering...."</p> <p>The resident had a Care Plan, dated 9/12/13, that addressed the problem Resistive to care due to decreased comprehension and progressive dementia and 8/5/14 required antipsychotic and antidepressant medications.</p> <p>Approaches included, but were not limited to, "1/10/12--...Monitor for behaviors...."</p> <p>The resident had a Care Plan, undated, that addressed the problem physical behavior toward other residents.</p> <p>Approaches included, but were not limited to, "7/31/14--1. Redirect resident away from peers rooms...8/15/14--3. Walk with the resident 5. At first sign of frustration separate from source of agitation and take to an area where he can gain a sense of calm."</p> <p>"Behavior Detail Report" indicated the resident wandered into other resident rooms and the behavior was not easily altered, on the following dates: "3/27/14 at 9:15 p.m., 4/26/14 at 8:46 a.m., 7/04/14 at 10:29 p.m., 7/16/14 at 3:45 p.m.,</p>		<p>Committee policy.</p> <p>Residents utilizing a bed and/or chair alarm will have placement and function checked every shift on the Medication Administration Record (MAR)/Treatment Administration Record (TAR) to be signed by a licensed nurse.</p> <p>4. An Ad-Hoc Quality Assurance/Performance Improvement Meeting was held with the ED, DCS, Medical Director and 3 additional staff members on 9-25-14 to review the Facility's policies and procedures for Behavior Management, Behavior Monitoring, Incident and Accident Reporting, and Abuse Reporting and Investigation Process. The policies and procedures were adopted by the facility without changes.</p> <p>The ED/DCS will conduct Quality Improvement Monitoring of this process 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then</p>	

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  09/30/2014
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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>7/16/14 at 6:40 p.m., 7/18/14 at 10:22 p.m.,</p> <p>7/23/14 at 2:52 a.m., 7/27/14 at 9:58 p.m.,</p> <p>7/29/14 at 1:43 p.m., 08/06/14 at 8:52 p.m.,</p> <p>and 9/11/14 at 3:49 p.m."</p> <p>The Interdisciplinary Progress Notes had indicated the resident had intrusively wandered into other resident's rooms. On 7/22/14, the resident was wandering all evening into multiple residents' rooms and became somewhat hostile at times.</p> <p>On 7/23/14, the resident was found face down on the floor in another resident's room. He cussed the staff during the assessment.</p> <p>On 8/6/14, the resident continued to wander into other residents' rooms and took their food and drinks. He became combative when the staff attempted to redirect him.</p> <p>On 8/7/14, the nurse sent a fax to the Physician in regards to the resident wandering into other residents' rooms and taking their things. He became</p>		<p>1 x monthly for 3 months or until substantial compliance is achieved. The ED/DCS will report findings to the Quality Assurance/Performance Improvement Committee 1 x monthly for 6 months for continued improvement or until substantial compliance is achieved</p> <p>The Activities Director/ SSD will conduct QI monitoring to ensure individualized activity care plans to meet the needs of residents with maladaptive behaviors. QI monitoring will be conducted via observation and/or record review five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months using a sample size of three residents with maladaptive behaviors. The Activities Director/ SSD will report findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the</p>	

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069			
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	<p>combative and hit staff when they attempted to redirect him.</p> <p>On 9/13/14, the resident wandered up and down the hallways and in and out of the residents' rooms.</p> <p>On 9/15/14, the resident wandered up and down the hallways and into other residents' rooms</p> <p>The resident had resident to resident altercations with these residents: On 7/22/14 at 6 A.M., Resident #8 reported that Resident #66 hit and grabbed her left upper arm as he tried to enter her room.</p> <p>On 7/24/14 AT 5:30 P.M., Resident #66 walked into Resident #82's room where he and a family member were visiting with his dog. Resident #66 started to pet Resident #82's dog, then became agitated and cursed at the dog. Resident #66 picked up a pillow and threw it at Resident #82.</p> <p>On 8/19/14 at 7:20 A.M., Resident #66 was ambulating in the North hallway common area when he grabbed Resident #68's arm. Resident #68 raised his fist to Resident #66 and Resident #68 did the same back to him.</p>		<p>continued time schedule for further monitoring,</p> <p>5. Date of Compliance: October 30, 2014</p>				

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 09/30/2014	
NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069			
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	<p>During an interview on 09/25/2014 at 2:44 P.M., Resident #19 indicated during the night an old man walked into her room with her door closed unannounced and she yelled at him to get out or she would hit him with her walker. She indicated he scared her. She indicated she had her walker by her bedside and if he did not leave when she told him to, she would hit him with her walker because she did not want men in her room. She indicated she had not told any staff that she was afraid of the man coming into her room because no one (staff) was your friend They did not help anyone here when you need help, so that was why she did not tell them. She indicated, "I will use my walker and fight him off."</p> <p>During an interview on 09/25/2014 at 2:53 P.M., Resident #88 indicated that a male roamed into her room one day this week with a blank stare on his face. She indicated she was not afraid because she had 6 other people in her room visiting her, but if she was alone she might be afraid of him if he roamed into her room.</p> <p>During an interview on 09/25/2014 2:54 P.M., Resident #60 indicated she had a male resident who was not really all there who has wandered into her room a couple of times in the past. She indicated she</p>						

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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(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
	<p>was afraid of him until the staff told her he would not hurt her. She indicated he came to the foot of her bed in the evenings and talked to her, but he really was not talking because he can not talk.</p> <p>During an interview on 09/25/2014 at 3:11 P.M., Resident #27 indicated no one had come into his room to his knowledge without his permission and they better not if they know what was good for them.</p> <p>During an interview on 09/25/2014 at 3:12 P.M., Resident #60 indicated Resident #66 came into his room and stood and looked around. He indicated he did not scare him.</p> <p>During an interview on 09/25/2014 3:34 P.M., NA [Nursing Assistant] #1 indicated other residents did not like it when residents wandered into their rooms. She indicated Resident #33 and Resident #66 were the residents who intrusively wandered into other residents' rooms.</p> <p>During an interview on 09/25/2014 at 3:37 P.M., CNA #2 indicated some of the residents were annoyed and impatient when the residents wandered into their rooms and want them out of their room. He indicated the residents that wandered were Resident #66 and Resident #57.</p>			

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  09/30/2014
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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>During an interview on 09/25/2014 at 3:39 P.M., LPN #3 indicated other residents objected when Resident #66 was ambulating by himself. He would wander into the resident rooms.</p> <p>During an interview with the Regional Director of Clinical Services (RDCS) on 09/25/2014 at 2:37 P.M., additional information was requested regarding Resident # 66's intrusive wandering.</p> <p>During interview on 09/25/2014 at 3:31 P.M., the RDCS indicated she had not gathered any information related to Resident # 66's intrusive wandering.</p> <p>During interview on 09/25/2014 3:59 P.M., the Director of Clinical Services (DCS) provided Resident Council meeting minutes for July 2014. The minutes indicated residents felt safe in the facility. He indicated these were the only resident interviews related to Resident #66's intrusive wandering and resident to resident altercations that could be located.</p> <p>During an interview on 09/25/2014 at 4:39 P.M., the RDCS indicated the staff informed her they had spoken to the resident's daughter. She said he had been on a dementia unit before. She had no</p>			

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>additional information to provide regarding the Psychiatric recommendation for a dementia unit or additional assessments or interventions for this resident.</p> <p>During an interview on 9/25/14 at 4:50 P.M., the Social Service Director indicated she was the staff member responsible for contacting a family member and discussing transferring their loved one to a facility with a secured dementia unit. She indicated she had not contacted the resident's family member who was responsible for him until today, regarding placing him on a secured dementia unit. She indicated the family member indicated she would talk to the rest of the family and let her know, but she was not surprised and had been expecting this.</p> <p>The Social Service Director indicated she had not documented any follow-up on this resident since 7/26/14. She indicated she thought she had followed up on his psychosocial needs after the resident to resident altercation on 7/22/14 and 7/24/14 , but after she reviewed the Interdisciplinary Progress Notes she indicated she had not followed up with the resident.</p>			

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  09/30/2014
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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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(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
	<p>A2. The record for resident # 57 was reviewed on 9/26/14 at 8:21 a.m. Current diagnoses included, but were not limited to, dementia with behavior disturbances and psychiatric disorder with delusions.</p> <p>A plan of care, dated 5/12/14 and updated 8/12/14, indicated the resident wandered into others rooms, with approaches that included, but were not limited to, "redirect inappropriate behavior as needed." The goal indicated the resident would wander safely and be direct away from others rooms daily.</p> <p>A psychiatric progress note dated 6/20/14, indicated the resident wandered about and was "quick to anger! He will grab staff's arms/wrists &amp; [and] twist violently...."</p> <p>A psychiatric note, dated 7/24/14, indicated the resident had no safety awareness and poor impulse control.</p> <p>A social service note, dated 7/9/14, indicated the resident was up frequently during the night and easily annoyed.</p> <p>A 7/16/14 social service note, indicated the resident wandered frequently throughout the night.</p> <p>The Interdisciplinary Progress Notes</p>			

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  09/30/2014
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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>indicated the resident had intrusively wandered into other resident's rooms on the following dates:</p> <p>"6/19/14 at 10 p.m., continued to wander and entered several other resident rooms. The other residents used call lights to alert the staff the resident was in their room. Urinated in one of the other resident rooms.</p> <p>6/20/14 at 6 a.m., continued to wander into others rooms.</p> <p>6/21/14 at 5 a.m., continued to wander into others rooms.</p> <p>6/22/14 resident wandered up and down the halls.</p> <p>6/24/14 at 10 p.m., wandered into resident rooms many times throughout the evening requiring 1:1 supervision.</p> <p>6/27/14 and 6/28/14 continued to wander into others rooms.</p> <p>7/1/14 at 3 a.m., wandered into other resident rooms.</p> <p>7/4/14 at 6 a.m., wandered into other resident rooms.</p> <p>7/5/14 at 11:14 p.m., "...has continued to be active, mobile and going in other residents' rooms..."</p> <p>7/15/14 at 2:35 p.m., has exhibited aggressive behavior toward staff, hitting CNA in the stomach and twisting the thumb of a nurse. Has been wandering into other resident rooms needing frequent redirection.</p> <p>7/23/14 at 9 p.m., resident was up</p>			

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  09/30/2014
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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>wandering all shift continues on 15 minute checks, easily redirected, but continues to wander in and out of other resident rooms.</p> <p>7/24/14 at 9 p.m., continued to wander facility, enters other resident rooms, staff redirected multiple times when resident was found in other resident rooms. Continued on 15 min checks.</p> <p>7/28/14 at 4 a.m., continued to wander into other resident rooms, on 15 minute checks.</p> <p>8/3/14 started on an antibiotic and on 8/11/14 he was in a wheelchair.</p> <p>8/20/14 at 9 p.m., wandered up and down the halls and in and out of other resident rooms...."</p> <p>During an interview on 09/25/2014 at 3:16 P.M., Resident # 8 indicated Resident #57 came into her room at night and once he tried to crawl into bed with her and had hit her on the leg. She indicated there was another resident that lived at the other end of the hallway that came into her room at night and he slapped at her leg also. She indicated was frightened when these men came into her room. She indicated she had told the nurses when they came to get Resident #57 and the other man out of her room that she was afraid of them. She indicated the staff informed her they could not help that these residents</p>			

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>wandered, but they would try to keep them out of her room.</p> <p>During an interview on 09/25/2014 at 3:37 P.M., CNA #2 indicated some of the residents were annoyed and impatient when the residents wandered into their rooms and want them out of their room. He indicated Resident # 57 wandered.</p> <p>A3. The record for resident # 33 was reviewed on 9/26/14 at 9:27 a.m. Current diagnoses included, but were not limited to, dementia with behavioral disturbances.</p> <p>A plan of care, dated 9/22/14, indicated the resident was combative with care, hitting, grabbing and yelling. The plan also indicated he wandered about the facility and his behavior would escalate with redirection. Approaches included, but were not limited to, "redirect the resident by talking to him about his wife."</p> <p>A 9/22/14 social service note indicated the resident wandered in the facility.</p> <p>Nursing notes indicated, on 7/5/14, wandered down the halls.</p> <p>A "Behavior Detail Report" indicated the resident wandered into other resident</p>			

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 09/30/2014	
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			
	<p>rooms on 4/4/14 and was not easily altered. The report also indicated the resident was verbally and physically abusive to staff, by hitting, punching, kicking, shoving, screaming, cursing, and scratching. The report indicated the resident wandered in the hallways and common areas.</p> <p>During an interview on 09/25/2014 at 3:34 P.M., NA #1 indicated Resident #33 intrusively wandered into other residents' rooms.</p> <p>During an interview on 09/25/2014 at 3:39 P.M., LPN #3 indicated other residents objected when Resident #33 intrusively wandered into their rooms.</p> <p>A4. On 9/30/14 at 10:20 a.m., CNA #9 indicated they were very short staffed. She indicated she had worked here for 5 years and this is the worse it has been. She indicated Resident # 57 was one on one while the survey was on-going and the survey was completed. She indicated there are just not enough staff to keep an eye on Residents # 66, # 57 and # 33. She indicated the staff that are present do not help answer lights or keep an eye on residents as much as they should.</p> <p>On 9/30/14 at 11:00 a.m., CNA #12 indicated Resident # 66 and # 57</p>						

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069			
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	<p>wandered a lot. CNA #12 indicated it was very difficult in the evening. She indicated the CNA's tried to do activities, but the residents would get up and walk away. CNA# 12 indicated there was just not enough help to watch the residents.</p> <p>A5. A policy titled "Behavior Monitoring" was provided by the RDCO on 9/26/14 at 9:30 a.m., and deemed as current. The policy indicated: "Policy Residents demonstrating behaviors that place a resident at risk, or interfere with care and other residents will be monitored and interventions initiated as an individualized approach to minimizing behavior...11. Interdisciplinary team will review behaviors, causative factors/triggers and or root cause to determine individualized interventions to minimize or eliminate targeted behaviors. 12. Resident's plans of care will be updated as needed."</p> <p>B. 1. On 9/23/14 at 9:35 A.M., Resident #66 was observed laying in bed and his bed alarm box did not indicate it was functioning. The light to indicate "in use" was not flashing green.</p> <p>On 9/23/14 at 10:57 A.M., the resident was observed laying in bed and his bed alarm box did not indicate it was functioning. The light to indicate "in use" was not flashing green.</p>						

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069			
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	<p>On 9/23/14 at 11:47 A.M., CNA #9 and CNA #12 were observed transferring the resident from the bed to a standing position. When the two CNA's transferred the resident to a standing position at the side of the bed, there was no alarming sound observed from the alarm box to indicate the bed alarm was functioning and the green light that indicated "in use" was not flashing. Neither CNA were observed checking the alarm box and pad when the box did not alarm. CNA #12 ambulated the resident to the North end dining room to eat lunch. When Resident #66 sat in the dining room chair, there was no chair alarm observed on the chair seat.</p> <p>On 09/23/2014 at 3:19 P.M., the resident was observed laying in bed and his bed alarm box did not indicate it was functioning. The light to indicate "in use" was not flashing green.</p> <p>On 9/23/14 at 5:00 P.M., the resident was observed laying in bed and his bed alarm box did not indicate it was functioning. The light to indicate "in use" was not flashing green.</p> <p>During an interview on 9/23/14 at 5:10 P.M., the DCS indicated the resident's bed alarm box was not on or was not</p>						

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069			
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	<p>functioning.</p> <p>During an interview on 9/23/14 at 5:12 P.M., LPN #3 indicated she did not know the resident's alarm was not functioning. She had not checked his bed alarm for proper functioning since she came on shift today because he had not gotten out of bed on this shift yet. She indicated the resident was usually up ambulating around by himself getting into everything. She indicated there was no place on the Medication Administration Record to document that the bed alarm had been checked each shift, so she could not indicate the bed alarm had been checked each shift and was functioning.</p> <p>During an interview on 9/23/14 at 5:20 P.M., the DCS indicated he changed the battery in the bed alarm box and changed the bed alarm pad on the resident's bed and the resident's bed alarm was functioning appropriately now.</p> <p>On 9/23/14 at 5:25 P.M., NA #1 and CNA #14 were ambulating the resident down to the dining room for dinner. They indicated at times it required two CNA's to ambulate the resident depending on how unsteady he was on his feet. When Resident #66 sat in the dining room chair, there was no chair alarm observed on the seat.</p>						

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

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	<p>On 9/24/14 at 11:00 A.M., the resident was observed sitting in the North end lounge in a recliner chair and no chair alarm was observed on the recliner chair.</p> <p>On 9/24/14 at 11:35 A.M., Activities Staff Member #13 left the North end lounge to transport another resident to the Main dining room leaving Resident #66 unattended until 11:37 A.M. when two CNA's came into the dining room to check another resident's wheelchair then they left. At 11:38 A.M., Activities Staff Member #13 came back and transported another resident to the Main dining room and left Resident #66 unattended. At 11:42 A.M., LPN #5 walked into the nurses' station across from the lounge then left the station. At 11:44 A.M., CNA #12 and LPN #5 were observed transferring Resident #66 out of the recliner chair to ambulate him. There was no alarm sounding when the staff transferred the resident out of the recliner chair. There was no pad for a chair alarm in the recliner chair after he was transferred.</p> <p>On 9/24/14 at 1:10 P.M., Resident #66 was sitting at a table unattended in the North end lounge without a chair alarm under him on the chair.</p>			

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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			
	<p>On 9/24/14 at 1:16 P.M., the resident stood up unassisted from the chair he was sitting in at the lounge table and there was no chair alarm sounding when he stood up. The Social Service Designee was at the table at this time talking to a family member and sat the resident back down in the chair.</p> <p>Resident #66's record was reviewed on 9/24/14 at 11:09 A.M. Diagnoses included, but were not limited to, dementia with behavior disturbances, difficulty in walking, muscle weakness, altered mental status, lack of coordination, impulsivity and behavior disturbances and chronic insomnia.</p> <p>The Quarterly Minimum Data Set assessment (MDS) dated 5/15/14, indicated the resident's cognitive skills for daily decision making were severely impaired.</p> <p>The resident's functional status for transfers indicated he was an extensive assist and one person physical assist. He required an extensive assist with one person physical assist for his locomotion. Walking in his room or the hallways he required limited assist and one person physical assist.</p> <p>A Physician Orders recap (recapitulation), dated September 2014,</p>						

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--	---	--	---

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

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	<p>included, but were not limited to, the following orders: Original order date 3/25/14-Bed and chair alarm at all times. Original order date 3/24/14-Bed alarm while in bed. Check function and presence every shift. Original order date 3/24/14-Up with assist with one person.</p> <p>The resident had a Care Plan, dated 9/12/13, that addressed the problem required assistance with transferring and ambulating and history of falls with the last three months.</p> <p>Approaches included, but were not limited to, "9/12/13-...Assist w/ [with] 1, Utilize alarm Type: Bed &amp; chair...7/23/14-15 min [minute] checks x [times] 72 hours...."</p> <p>On 9/25/14 at 9:15 A.M., the "Fall Investigation" reports from all the resident's falls from 6/12/14 to 9/14/14 and the 15 minute checks for the 7/23/14 fall was requested from the Director of Clinical Services (DCS).</p> <p>During an interview on 9/23/14 at 9:49 A.M., the Assistant Director of Clinical Services (ADCS) indicated the resident ambulated and wandered the hallways at night and when he was ready for bed he</p>			

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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(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
	<p>sat down on the floor.</p> <p>The "Interdisciplinary Progress Notes" and "Fall Worksheet for Incident/Accident/Unusual Occurrence Reporting" document indicated Resident #66 had a history of falls.</p> <p>On 6/12/14 at 8 P.M., the resident had an unwitnessed fall and was found on the floor in the North end dining room. He was found on the floor. Prior to the fall, he was observed standing up in the space between the seat of the wheelchair and the elevated foot rests. Two hours prior to the fall, the resident had been easily redirected to sit back down into the wheelchair several times. There was no bruising or redness found upon assessment of the resident. The resident had not had a bowel movement for 3 days prior to the fall. The "Fall Follow-up Assessment" indicated there were no alarms in place as an intervention at the time of the fall.</p> <p>On 7/4/14 at 7:45 P.M., the resident had an unwitnessed fall and was found by a CNA on the floor laying on his left side. He had bleeding from the left side of his head and had lost consciousness for one minute after the fall. Emergency 911 was called due to a possible head injury. The resident had been side stepping and</p>			

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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069			
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	<p>looking at his feet while ambulating earlier in the shift. The "Fall Follow-up Assessment" indicated there were no alarms in place as an intervention at the time of the fall. At 8:15 P.M., when 911 arrived to transfer the resident to the hospital, a left frontal head laceration approximately one inch in length was discovered with a large amount of coagulated blood on his left cheek. The resident had slight bruising at his left cheek and left eye orbit.</p> <p>On 7/5/14 at 12:20 P.M., the resident returned from the hospital with five staples to the left side of his forehead.</p> <p>An "Emergency Department Physician Medical Record", dated 7/4/14, indicated Resident #66's chief complaint for being at the Emergency Room was a fall. The record indicated the resident had a four centimeter vertical laceration to his left forehead and he received five staples to the laceration. The record indicated the resident had a Head injury with dementia and a facial laceration.</p> <p>During an interview on 9/24/14 at 4:28 P.M., the Medical Records staff member indicated the resident's orders for the September 2014, Medication Administration Record (MAR) were dated for 7/5/14, but were the same</p>						

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--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>orders he originally had when he was admitted back from the hospital on 3/24/14. She indicated when he went to the Emergency room on 7/4/14, he was not back by midnight, so the way their computer system functioned the nurses had to discharge him. When he came back to the facility on 7/5/14 after midnight the computer automatically dated the residents' orders with the new admission date even if they have not been gone over 24 hours.</p> <p>On 7/15/14 at 12:10 A.M., the resident had a witnessed fall. He was by the nurses station in the hallway and lost his balance and fell backwards landing on his buttocks. No visible injuries. The "Fall Worksheet for Incident/Accident/Unusual Occurrence Reporting" document indicated he did not have any personal or sensor alarms on at the time of the fall.</p> <p>On 7/23/14 at 10:50 A.M., the resident had an unwitnessed fall while wandering throughout the facility and was found in another resident's room on the floor. He had a small bruise with an abrasion noted to the left side of his forehead. The immediate intervention was 15 minute checks for 72 hours. The "Fall Worksheet for Incident/Accident/Unusual Occurrence Reporting" document indicated he did not have any personal or</p>			

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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
	<p>sensor alarms on at the time of the fall.</p> <p>On 8/3/14 at 6:45 P.M., the resident had an unwitnessed fall and was found by another resident sitting on the floor on his buttocks. There were no injuries found upon assessment of the resident. The "Fall Follow-up Assessment" indicated there were no alarms in place as an intervention at the time of the fall.</p> <p>On 8/17/14 at 8 P.M., the resident had an unwitnessed fall. He was found in the Southside lounge laying on his left side. There were no injuries found upon assessment of the resident. The "Fall Followup Assessment" indicated alarms were in place at the time of the fall, but the record did not indicate whether the alarms were ringing at the time of the fall. The "Fall Investigation" indicated the resident was ambulating in the hallway prior to the fall and he tripped over his own feet. It also indicated there was no new intervention implemented after this fall.</p> <p>On 9/14/14 at 9:50 P.M., the resident had an unwitnessed fall in another resident's room. He was found sitting on the floor on his buttocks, then laid onto his back. The resident was ambulating prior to being found on the floor. There were no injuries noted upon assessment of the</p>			

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  09/30/2014
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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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(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
	<p>resident after the fall. The "Fall Follow-up Assessment" indicated there were no alarms in place at the time of the fall. The "Fall Investigation" document indicated there was no new interventions initiated after the resident's fall.</p> <p>During an interview on 9/25/14 at 1:48 P.M., the DCS indicated he could not find the fall report for 6/12/14, 7/4/14, and 8/3/14. He indicated he had called the prior DCS and she had told him where to look for them, but he was unable to locate them. He indicated he did not realize the resident was to have a chair alarm or was to be up with one assist.</p> <p>During an interview on 9/29/14 at 10:15 A.M., the ADCS indicated the resident was in an unoccupied room on 7/4/14 when he fell and sustained the laceration to the left side of his head and the head injury. She indicated the "Fall Investigation" report could not be found for this fall and the immediate intervention was to send him to the Emergency Room for treatment. She indicated she could not remember the new intervention for this fall.</p> <p>During an interview on 9/30/14 at 9:18 A.M., the DCS indicated the initials in the box for the night and dayshift on</p>			

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 09/30/2014	
NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069			
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	<p>9/23/14, for the order Bed alarm-Check function and placement every shift did not indicate the bed alarm was checked for function and placement for those two shifts. He indicated that order was initiated on the September 2014, MAR on 9/23/14 on the evening shift. DCS indicated he could not locate the 72 hour 15 minute checks that were completed for Resident #66's 7/23/14 fall.</p> <p>B2. Resident #47's record was reviewed on 9/24/2014 at 5:20 P.M. Diagnoses included, but were not limited to, iron deficiency anemia, dementia, depressive disorder and macular degeneration (a condition that can slowly or suddenly produce a painless loss of vision) .</p> <p>The resident's document, "Fall Risk Identification and Plan of Care", dated 8/22/13, indicated the resident was not consistently oriented to her own limitations. The back of the document, "Risk Identification Review" indicated the resident fell on 9/12/13 and 1/22/14 and that interventions were updated.</p> <p>The resident's record indicated the resident had a recent fall on 7/21/14. The "Fall Investigation", dated as having occurred on 7/21/14, indicated the resident fell and sustained a facial hematoma. Under care plan must be</p>						

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  09/30/2014
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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>updated, it indicated the following, "...Indicate what caused the accident...Res[resident] left unattended in room, res. attempted to wheel self into hallway [sign for with] brakes locked. When res couldn't go she attempted to stand resulting in fall."</p> <p>The resident's record lacked an updated care plan. During an interview on 9/30/14 at 10:35 A.M., the Assistant Director of Clinical Services indicated she thought she had updated the care plan, but was unable to find the update revising the care plan that indicated the resident should not be left unattended.</p> <p>At this time the Director of Clinical Services (DCS) indicated the procedure should be that a fall's root cause should be identified. Interventions should be written and they should go along with the identified root cause of the fall to prevent reoccurrence.</p> <p>As of exit on 9/30/14 at 2:15 P.M., no other information was provided.</p> <p>The immediate jeopardy that began on 9/25/14 was removed on 9/26/14 when the facility had discharged Resident #66 to the hospital and placed Resident # 57 and # 33 on 1:1 supervision. All staff in servicing had been completed for staff</p>			

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  09/30/2014	
NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069			
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F000329 SS=D	<p>prior to beginning their shifts for all departments. A Behavior Management Meeting was held on 9/25/14 and the care plans for Resident # 57 and # 33 were updated. Resident interview had been completed for interviewable residents and total body assessments had been completed for non-interviewable residents. The noncompliance remained a lower scope and severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy.</p> <p>3.1-45(a)(1) 3.1-45(a)(2) 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs</p>						

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  09/30/2014
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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to ensure specific behaviors were identified and quantitatively monitored to support the use of psychotropic medications for 2 of 5 residents reviewed for Unnecessary Medications. In addition the facility failed to have non-pharmacological interventions for dementia residents with wandering behaviors. (Residents #28 and #66).</p> <p>Findings include:</p> <p>1. Resident #28's record was reviewed on 9/26/14 at 3:24 P.M. Diagnoses included, but were not limited to, dementia with behavior disturbance, depression, anxiety, and paranoid delusions.</p> <p>The resident's physician medication order recapitulation for the month of September 2014 indicated the resident's medications included, but were not limited to the following:</p> <p>On 2/24/14, the anti-anxiety medication Ativan 0.5 mg (milligrams), po (orally), tid (3 times per day) was ordered.</p> <p>On 2/24/14, the anti-anxiety medication</p>	F000329	<p>F-329</p> <p>1. Resident # 28 last gradual dose reduction (GDR) attempt was 9/25/14 and the resident was reviewed by the consultant pharmacist on 10/08/14. Resident # 66 no longer resides at the facility.</p> <p>2. Residents receiving psychotropic medications and/or wandering behavior have the potential to be affected by this alleged deficient practice. A behavioral management meeting will be held by the IDT to identify targeted behaviors and ensure non-pharmacological interventions for wandering residents by October 28, 2014.</p> <p>3. On 9-25-14, the Regional Director of Clinical Services re-educated the Interdisciplinary team (IDT) including the Executive Director, Director of Clinical Services, Social Services Director, Activities Director, Assistant Director of Clinical Services and Minimum Data Set (MDS) Coordinator on the Behavior Management,</p>	10/30/2014

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  09/30/2014
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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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(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
	<p>Buspar 15 mg, po, qid (4 times per day) was ordered.</p> <p>On 2/24/14, the anti-depressant Remeron 5 mg, po, hs(at bedtime) was ordered.</p> <p>On 4/4/14, the anti-psychotic Seroquel 100 mg, po, qhs was ordered.</p> <p>On 5/3/14, the anti-depressant Trazadone 25 mg, po (orally), every 6 hours to be given as needed for increased anxiety was ordered.</p> <p>On 6/20/14, the anti-psychotic medication Seroquel 50 mg, po, bid (2 times per day) was ordered.</p> <p>On 8/28/14, the anti-depressant Trazadone 50 mg, po, at bedtime was ordered.</p> <p>The resident's care plan for behavior symptoms under approaches indicated the following:</p> <p>"2/23/14 wanderguard. 3/30/14 Depakote[anti-seizure medication] 250 milligrams [mg] TID [3 times per day]... 6/20/14 Seroquel [anti- psychotic medication] 50 mg every a.m., 50 at 1:00 P.M. and 100 at bedtime... 9/22/14 Seroquel 50 mg BID[2 times per day]. Seroquel mg 75 at bedtime...."</p> <p>The "Behavior Detail Report," for May 2014, July 2014, August 2014 and</p>		<p>Behavior Monitoring, Accident and Incident Reporting and Investigating, and Abuse Reporting and the Investigation Process.</p> <p>On 9-25-14, the Director of Clinical Services (DCS)/Assistant Director of Clinical Services (ADCS) initiated education for facility staff to intervene and report behaviors to their supervisor for documentation in the medical record, behavior monitoring sheet and 24 hour report, along with updating of the care plan and any required follow up by the IDT-to include but not be limited to reporting to the State of Indiana within 24 hours and completing a 5 day investigation.</p> <p>On October 20, 2014 the RDSC re-educated the SSD on the regulation F250 and the facility's policies on: Social Services, Team Approach, Progress Notes, and Episodic Notes. The SSD received education from an outside consultant on October 17th and 22nd, 2014 on the regulations F250 &amp; F225, Care Plan development and Behavior Management. The outside consulting company will provide ongoing consulting monthly for six months.</p> <p>4. The SSD/ Nurse Manager will conduct QI monitoring of the regulation F329 to ensure specific</p>	

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  09/30/2014
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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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	<p>September 2014 indicated the following was observed:</p> <p>In May 2014, the report indicated, "5/3/14 2:13 P.M., wandered in hall. Wandered throughout facility. Screaming. Was inappropriate behavior easily changed? No...</p> <p>5/6/14 10:30 A.M., refused bath or shower. Was redirection effective for resisting care? No.</p> <p>5/7/14 12:52 P.M. Describe the socially inappropriate behavior Other. 1 to 1 yes.</p> <p>5/8/14 9:02 A.M., refused personal hygiene.</p> <p>5/9/14 8:56 A.M., refused bath or shower. 1 to 1 yes...</p> <p>5/15/14 12:07 P.M., describe physically resistant behavior. Other. Was resistance easily changed? No.</p> <p>5/20/14 12:02 P.M., refused bath or shower. 1 to 1 yes.</p> <p>5/22/14 9:55 P.M., wandered in hall. Was wandering easily changed? No.</p> <p>5/28/14 6:30 P.M., wandered in hall. Was redirection effective for wandering?</p>		<p>behaviors were identified and quantitatively monitored to support the use of psychotropic medications and to ensure non-pharmacological interventions for dementia residents with wandering behaviors. QI monitoring will be conducted via observation and/or record review five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months using a sample size of five random residents. The SSD/ Nurse Manager will report findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring,</p> <p>5. Date of Compliance: October 30, 2014</p>	

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  09/30/2014
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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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(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
	<p>No...."</p> <p>In July 2014, the report indicated,"7/25/14 1:48 P.M. Describe the socially inappropriate behavior. Screaming. Was inappropriate behavior easily changed? No...."</p> <p>In August 2014, the report indicated,"8/22/14 10:40 A.M. Describe physically resistant behavior. Refused bath or shower. Was resistance easily changed? No. 1 to 1 Yes...."</p> <p>In September 2014, the report indicated, "9/20/14 at 9:48 P.M. Socially inappropriate behavior. Describe the socially inappropriate? Screaming. 1 to 1 yes...</p> <p>9/25/14 at 12:02 P.M. Describe the socially inappropriate behavior. Other. Was socially inappropriate behavior easily changed? Yes...."</p> <p>During an interview on 9/26/2014 at 1:40 P.M., with the Social Service Designee, she indicated no specific targeted behaviors were being monitored. If there were behaviors, they were documented on the computer and in the chart.</p> <p>2. Resident #66's record was reviewed on 9/24/14 at 11:09 A.M. Diagnoses</p>			

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  09/30/2014
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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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(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
	<p>included, but were not limited to, dementia with behavior disturbances, altered mental status, cognitive communicative deficit, psychological disease with hallucinations other disease, Late onset dementia consider frontal lobe syndrome now with mood liability, impulsivity and behavior disturbances, anxiety and depression related to illness, Alzheimer's disease and chronic insomnia.</p> <p>The resident's Physician order recap (Recapitulation) dated September 2014, included, but were not limited to, the following orders: Original order 3/24/14-Klonopin (An Anti-anxiety medication) 0.25 milligrams (mg) by mouth daily at 6 P.M. Original order 3/24/14-Trazadone (An antidepressant medication) 50 mg by mouth at bedtime Original order 3/24/14-Psychiatric Evaluation and Treatment by Psychiatrist as indicated by (Physicians name). Original order 4/2/14-Hold Psychiatric medication for lethargy Original 6/16/14-Psychiatric Evaluation and Treatment by Psychiatrist on site 7/24/14-Risperdal (An antipsychotic medication) 0.25 mg by mouth daily at 5 P.M. 7/24/14-Depakote Sprinkles (A mood stabilizer medication) 375 mg by mouth</p>			

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  09/30/2014
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NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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(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
	<p>every evening. Hold any dose for daytime sedation.</p> <p>7/24/14-Depakote Sprinkles (A mood stabilizer medication) 250 mg by mouth every morning. Hold any dose for daytime sedation. (Decreased on 9/24/14)</p> <p>8/01/14-Increased Zoloft (An antidepressant medication) 75 mg by mouth daily</p> <p>9/24/14-Decrease Depakote to 125 mg in the morning</p> <p>The resident had a Care Plan, dated 8/5/14, that indicated he required an Antipsychotic and an Antidepressant medication.</p> <p>Approaches included, but were not limited to, "8/10/13--Depakote: hold for lethargy, Monitor for S/E [side effects], Monitor behaviors...."</p> <p>Resident #66 was admitted to the facility after a hospitalization admission to a Geri-psychiatric Hospital in March 2014.</p> <p>A "Psychiatry Progress Note and Treatment Summary", dated 7/24/14, indicated "Asked to see emergently, with more anger, aggression &amp; quite agitation; Esp [especially] since VPA [Depakote]/risperdal dose reduction on 7/9/14 (too sluggish then). No safety awareness at all now. Recent fall on</p>			

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  09/30/2014	
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			
	<p>7/15/14 (No injuries reported). Gait: SBA [Stand By Assist] at times. Mood: Quick to anger!.. Psychotropic medication (s) reviewed. Dosage IS Not indicated at this time. If reduction is not indicated, reason: Previous Reductions have failed... Impression/Plan: Medications: 1. Increase Depakote Sprinkle to 250 mg Q [every] A.M. &amp; 375 mg Q 5 P.M. 2. resume Risperdal 0.25 mg Q 5 P.M. (delusions/aggression) 3. Cont [continue] Klonopin 0.25 mg Q 5 P.M. 4. Now Zolofl 75 mg Q A.M. (Recent Increase) Behavioral Recommendations: He remains impulsive &amp; lacks safety awareness. May be better on a secured dementia unit."</p> <p>On 4/6/14, a Daily Skill Nurse's Note indicated he had behavioral problems of physical behaviors such as hitting or kicking and verbal behaviors such as screaming and cursing.</p> <p>On 4/5/14 a Daily Skill Nurse's Note indicated he had behavior problems of Physical Behaviors such as hitting and or kicking during care and Verbal behaviors such as screaming and or cursing. during care</p> <p>On 5/26/14, a Daily Skilled Nurse's Note indicated the resident was up all night. He ambulated and was redirected back to bed three times, redirected back to the recliner three times and placed in the</p>						

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  09/30/2014
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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
	<p>wheelchair three times. All interventions were unsuccessful. Snacks and drinks were offered twice and were ineffective.</p> <p>On 6/11/14, a Weekly Nursing Progress Notes in the behavior section indicated the resident became aggressive with care at times the last seven days</p> <p>On 7/8/14 at 10:30 A.M., an Interdisciplinary Progress Notes indicated the resident was laying in bed and aroused to contact and voice then drifted back to sleep.</p> <p>On 7/8/14 at 11:20 A.M., an Interdisciplinary Progress Notes indicated the resident was in the hall ambulating with assistance with a shuffled unsteady gait. The resident had a slight lean to the left while sitting at the table for lunch.</p> <p>On 7/8/14 at 9 P.M., an Interdisciplinary Progress Notes indicated the resident ate his dinner in bed</p> <p>On 7/9/14, a Weekly Nursing Progress Notes behavior section indicated the resident wandered and resisted care the last 7 days</p> <p>On 7/12/14 at 9 A.M., an Interdisciplinary Progress Notes indicated the resident was agitated at meal time and wanted to take another resident's food and when the nurse attempted to redirect the resident he hit the nurse's hand several times and then left the dining room.</p> <p>On 7/14/14 at 6:30 P.M., an</p>			

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  09/30/2014	
NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069			
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	<p>Interdisciplinary Progress Notes indicated the resident had increased wandering around the hallway before supper, but was easily redirected.</p> <p>On 7/16/14, a Weekly Nursing Progress Notes in the behavior section indicated the resident had wandering and resistive to care at times the last 7 days.</p> <p>On 7/22/14 at 6 A.M., an Interdisciplinary Progress Notes indicated another resident reported (not witnessed by the nurse) to a nurse at that time this resident hit and grabbed another resident by the left upper arm. The resident had increased behavior and wandering.</p> <p>On 7/22/14 10 P.M., an Interdisciplinary Progress Notes indicated the resident had been up all evening wandering and had been removed from multiple residents rooms and became "somewhat hostile at times."</p> <p>On 7/23/14 at 10:50 A.M., an Interdisciplinary Progress Notes indicated the resident was cussing the nurse when she was assessing him after a fall.</p> <p>On 7/23/14, a Weekly Nursing Progress Notes behavior section indicated the resident wandered and was resistive to care at times the last 7 days.</p> <p>On 7/24/14 at 5:30 P.M., an Interdisciplinary Progress notes indicated the resident hit another resident in that resident's room with a pillow. He was immediately removed from the area and</p>						

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  09/30/2014
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	<p>placed on 1:1 until further evaluation could be completed. The Psychiatrist was in the facility during the incident, so he gave new orders for Risperdal 0.25 mg by mouth at 5 P.M., Increased the resident's Depakote to 250 mg every A.M. and 375 mg by mouth at 5 P.M.</p> <p>On 9/23/14 at 9:35 A.M., the resident was observed to have his eyes closed and could not be aroused.</p> <p>On 9/23/14 at 10:57 A.M., the resident was observed to have his eyes closed and could not be aroused.</p> <p>On 9/23/14 at 11:47 A.M., CNA #9 was observed ambulating the resident to lunch. The resident was leaning to the left while walking to the dining room and the CNA #9 indicated that was not "like him" to lean while he was ambulating.</p> <p>On 09/23/2014 at 3:19 P.M., the resident was observed to have his eyes closed and could not be aroused.</p> <p>During an interview on 9/23/14 at 5:12 P.M., LPN #3 indicated the dayshift nurse reported to her that the resident had not been doing well lately and now that she thought about it, the resident had to be brought back to his room in a wheelchair last night after dinner and that</p>			

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	<p>was not like him. She indicated the resident was usually up ambulating around by himself getting into everything.</p> <p>On 9/23/14 at 5:25 P.M., NA #1 and CNA #14 were ambulating the resident to the dining room for dinner. CNA #14 indicated at times it required two CNA's to ambulate the resident depending on how unsteady he was on his feet.</p> <p>On 9/24/14 at 11:00 A.M., the resident was observed sitting in a recliner. The recliner was tipped back with his feet propped up with the bottom of the recliner in the North end lounge. He was observed with his eyes closed.</p> <p>On 9/24/14 at 11:44 A.M., CNA #12 and LPN #5 was observed transferring Resident #66 out of the recliner chair to ambulate him. At that time, CNA #12 indicated to LPN #5 regarding Resident #66, "He slept all the way through activities didn't he?" At that time, LPN #5 indicated he had slept through the activities.</p> <p>During an interview on 09/25/2014 at 3:39 P.M., LPN #3 indicated when Resident #66 was up ambulating by himself he would wander into the residents room. She indicated she had the</p>			

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	<p>doctor look at him yesterday and he decreased his medications due to possible over sedation.</p> <p>During an interview on 9/30/14 at 11:20 p.m., the Social Service Designee (SSD) indicated the facility had not had a Behavior management meeting in 6 months.</p> <p>During an interview on 9/30/14 at 11:56 A.M., the SSD indicated the specific targeted behaviors for the residents Klonopin was physical behaviors with staff, verbal behaviors with staff, resisting care and wandering. The specific targeted behaviors for the resident's Risperdal was delusions, but she had not seen any delusions documented from the staff to indicate the resident was having delusions. She indicated the Klonopin was used as a Mood Stabilizer for him.</p> <p>3. A current policy titled "Behavior management/Psychotropic Management Meeting" dated 02/20/2014, provided by the Regional Director of Clinical Services on 9/29/14 at 10:53 A.M., indicated "Policy: the facility will review residents with Behaviors and psychoactive medications weekly through an inter-disciplinary team process meeting. The interdisciplinary team</p>			

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F000353 SS=E	<p>meeting will review residents' current behaviors, causative factors and non-pharmacological and pharmacological interventions. Residents with Psychoactive medications in absence of behaviors will be reviewed quarterly according to an established schedule. Procedure: 1. The Interdisciplinary team will meet weekly to review residents with Behaviors and Residents with psychoactive medications, and document an inter-disciplinary team note in the clinical record. 2. Review of Behaviors should include. a. Description of current/recurring behavior (s)... e. Interventions to decrease to eliminate the behavior... 5... 1. Facility will maintain a schedule for quarterly review of residents with psychoactive medications in absence of behavior so that resident is reviewed a minimum of quarterly...."</p> <p>3.1-48(a)(3)</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by</p>				

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	<p>sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on interview and record review, the facility failed to provide enough staff to supervise residents that wandered for 3 of 3 residents that wandered (Residents #33, # 57 and # 66) and provide Range of Motion Services for 1 of 2 residents reviewed for Range of Motion. (Resident #20)</p> <p>Findings include:</p> <p>1 On 9/30/14 at 10:20 a.m., CNA #9 indicated they were very short staffed. She indicated she had worked here for 5 years and this is the worse it has been. She indicated Resident # 57 was one on one while the survey was on-going and the survey was completed. She indicated there are just not enough staff to keep an eye on Residents # 66, # 57 and # 33. She indicated the staff that are here do not help answer lights or keep an eye on residents as much as they should.</p>	F000353	<p>F-353</p> <ol style="list-style-type: none"> <li>Residents # 57 and 66 no longer reside in the facility. Resident # 33 was placed on 1:1 supervision until discharged to the hospital on 9/27/14. Resident #33 returned, status post hospital stay and medication adjustment. Resident currently on increased supervision. Resident # 20 will be screened by therapy services for recommendations on appropriate range of motion (ROM) services.</li> <li>All residents have the potential to be affected by this alleged deficient practice.</li> <li>The RDCS will re-educate the ED on the regulation F353 by October 28, 2014. The DCS, and Staffing Coordinator will communicate five times a week on the facility's staffing patterns.</li> <li>The ED/Staffing Coordinator will conduct QI</li> </ol>	10/30/2014	

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	<p>On 9/30/14 at 11:00 a.m., CNA #12 indicated Resident # 66 and # 57 wandered a lot. CNA #12 indicated it was very difficult in the evening. She indicated the CNA's tried to do activities, but the residents would get up and walk away. CNA# 12 indicated there was just not enough help to watch the residents.</p> <p>During an interview on 9/30/14 at 11:48 A.M., CNA #8 indicated she had to provide residents on the units resident care and she could not do her Restorative nursing duties because they were short staffed. She indicated she did not know what residents were on the Restorative nursing therapy caseload at this time. She indicated she had not been receiving the communication forms to indicate what residents were to receive Restorative nursing therapy after they were discharged from therapy.</p> <p>2. Resident # 66's record was reviewed on 9/24/14 at 11:09 A.M. Diagnoses included, but were not limited to, dementia with behavior disturbances, difficulty in walking, altered mental status, lack of coordination, cognitive communicate deficit, psychological disease with hallucination other disease, late onset dementia, consider frontal lobe syndrome now with mood lability,</p>		<p>monitoring of the regulation F353 to ensure enough staff to supervise residents that wandered and provide ROM services. QI monitoring will be conducted five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months. The ED/Staffing Coordinator will report findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring,</p> <p>5. Date of Compliance: October 30, 2014</p>	

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	<p>impulsivity and behavior disturbances, anxiety and depression related to illness, and chronic insomnia.</p> <p>A document titled "Psychiatric Evaluation", dated 2/11/14, indicated "...He has been very been wandering into other peers' rooms, he has been very focused on exploring the area at [name of facility] but, he is difficult to redirect and has created some increased anxiety amongst female peers because of his wanderings...The wandering is not going to respond to medication so providing a safe environment for him to wander would be likely an important piece of the environmental control. Unfortunately, when he wanders into peers' rooms that leads to increased peer-peer interaction and conflict."</p> <p>The resident had a Care Plan, dated 8/12/13, that addressed the problem of resident sensitive to care, resistive to care, poor safety awareness and impulse control, cursed at staff, hit and kicked staff, wandered, refused care and attempted to take other residents food.</p> <p>The Interdisciplinary Progress Notes had indicated the resident had intrusively wandered into other resident's rooms on the following dates: "7/22/14--The resident was wandering all</p>			

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	<p>evening into multiple residents' rooms and became somewhat hostile at times.</p> <p>7/23/14--The resident was found face down on the floor in another resident's room. He cussed the staff during the assessment.</p> <p>8/6/14--The resident continued to wander into other residents' rooms and took their food and drinks. He became combative with the staff attempted to redirect him.</p> <p>8/7/14--The nurse sent a fax to the Physician in regards to the resident wandering into other residents' rooms and taking their things. He became combative and hit staff when they attempted to redirect him.</p> <p>9/13/14--The resident wandered up and down the hallways and in and out of the residents' rooms.</p> <p>9/15/14--The resident wandered up and down the hallways and into other residents' rooms...."</p> <p>The progress notes for Resident #66 indicated, on 7/4/14 at 7:45 P.M., the resident was found on the floor in an unoccupied resident room on his left side with bleeding from the left side of his head. He lost consciousness for one</p>			

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	<p>minute after the fall. 911 was called.</p> <p>7/4/14 at 8:15 P.M., 911 arrived and the resident was noted to have a left frontal laceration approximately one inch in length with a large amount of blood coagulation noted on his left cheek. The resident had slight bruising at his left cheek and left eye orbit.</p> <p>8/3/14 at 6:45 P.M., Resident #66 was found by another resident to be sitting on the floor on his buttocks.</p> <p>3. The record for resident # 57 was reviewed on 9/26/14 at 8:21 a.m. Current diagnoses included, but were not limited to, dementia with behavior disturbances and psychiatric disorder with delusions.</p> <p>A plan of care dated 5/12/14 and updated 8/12/14 indicated the resident wandered into others rooms, with approaches that included, but were not limited to, redirect inappropriate behavior as needed. The goal indicated the resident would wander safely and be direct away from others rooms daily.</p> <p>A 7/16/14 social service note indicated the resident wandered frequently throughout the night.</p> <p>4. The record for resident # 33 was</p>				

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	<p>reviewed on 9/26/14 at 9:27 a.m. Current diagnoses included, but were not limited to, dementia with behavioral disturbances.</p> <p>A plan of care, dated 9/22/14, indicated the resident was combative with care, hitting, grabbing and yelling. The plan also indicated he wandered about the facility and his behavior would escalate with redirection. Approaches included, but were not limited to, redirect the resident by talking to him about his wife.</p> <p>A 9/22/14 social service note indicated the resident wandered in the facility.</p> <p>Nursing notes, dated 7/5/14, indicated "wanders down the halls."</p> <p>A "Behavior Detail Report" indicated the resident wandered into other resident rooms on 4/4/14 and was not easily altered.</p> <p>During an interview on 09/25/2014 at 3:34 P.M., NA #1 indicated Resident #33 intrusively wandered into other residents' rooms.</p> <p>During an interview on 09/25/2014 at 3:39 P.M., LPN #3 indicated other residents objected when Resident #33 intrusively wandered into their rooms.</p>			

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	<p>5. Resident #20's record was reviewed on 9/29/14 at 4:34 P.M. Diagnoses included, but were not limited to, end-stage dementia, left hand contracture and lack of coordination.</p> <p>The resident had a Care Plan dated 4/6/11, that addressed the problem left hand contracture. Approaches included, but were not limited to, "2/24/11-Remove, wash, dry, PROM [passive range of motion] QD [every day]...."</p> <p>During an interview on 9/23/14 at 10:32 A.M., the Assistant Director of Clinical Services (ADCS) indicated the resident had a contracture of the left hand. She indicated she received range of motion (ROM) services through Restorative nursing therapy, but the ROM services was not done as scheduled because the facility had been short staffed on CNA's and had been using agency often. She indicated the Restorative CNA's were taken away from their Restorative nursing job duties to cover as CNA's on the units providing resident care, so the ROM exercises were not being completed on the residents.</p> <p>During an interview on 9/30/14 at 11:55 A.M., the ADCS indicated Resident #20</p>				

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F000356 SS=C	<p>did not have any Restorative nursing therapy documentation to indicate that she had received Restorative nursing therapy after therapy had discharged her in August.</p> <p>6. On 9/22/14 at 2:22 p.m., Resident D indicated "sometimes they can't always get to you because they are too busy and there is not enough help."</p> <p>On 9/23/14 at 2:19 p.m., Resident C indicated "the end of last month she had to wait an hour and a half during the evening for staff to get her on the bed pan." She indicated the staff had not gotten to her in time and she had to sit in her urine.</p> <p>On 9/24/14 at 1:04 p.m., Resident #11 indicated there was not enough staff. She indicated she had put her "bathroom light on and had to wait over 30 minutes to get help."</p> <p>This Federal Tag relates to Complaint IN00155737</p> <p>3.1-17(a)</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:</p>						

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	<p>o Facility name.</p> <p>o The current date.</p> <p>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:</p> <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> <p>o Resident census.</p> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview, the facility failed to have daily staffing posted timely for 1 of 1 day observed for daily posted staffing. This deficient practice had the potential to affect 71 of 71 residents residing in the building.</p> <p>Findings include:</p> <p>On 9/22/14 at 11:32 A.M., the daily</p>	F000356	<p>F-356</p> <ol style="list-style-type: none"> <li>1. No resident was identified.</li> <li>2. The daily staffing was posted on 9/22/14 after being brought to the attention of the ED.</li> <li>3. The ED/DCS will re-educate licensed nurses and the staffing coordinator on the facility's Daily Posting of Nurse Staffing Data. The 3rd shift nurse on the south unit will post the daily staffing prior to</li> </ol>	10/30/2014

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  09/30/2014
NAME OF PROVIDER OR SUPPLIER  SHERIDAN REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069		
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F000441 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		ending the shift. The Staffing Coordinator will verify the daily staffing is posted at the start of the shift.  4. The ED/Staffing Coordinator will conduct QI monitoring of the regulation F356 to ensure daily staffing is posted timely. QI monitoring will be conducted three times a week for four weeks, weekly for eight weeks, then monthly for three months. The ED/Staffing Coordinator will report findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring,  5. Date of Compliance: October 30, 2014		

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  09/30/2014
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	<p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and record review, the facility failed to ensure respiratory equipment was clean and stored properly, failed to ensure nursing personal washed their hands the appropriate length of time and used gloves when appropriate for 2 of 6 residents observed for infection control . (Resident E and #32)</p> <p>Findings include:</p>	F000441	F-441 1. Resident E and # 32 show no apparent adverse affect from this alleged deficient practice. 2. All residents have the potential to be affected by this alleged deficient practice. Residents receiving nebulizer treatments will have the equipment checked by the Central Supply Clerk to ensure it is properly labeled and stored by October 28, 2014. 3. On October 9, 2014 the DCS/ Nurse	10/30/2014

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	<p>1. On 9/25/14 at 10:08 A.M., LPN #4 was observed administering Resident E's nebulizer treatment. LPN #5 was observed writing with a black permanent marker the name of the resident, date and room number of the resident on a plastic bag laying on the resident's overbed table. At that time LPN #5 indicated the resident had just been given new nebulizer equipment right before her nebulizer treatment was started. She indicated the old nebulizer equipment had been thrown in the trash can. She indicated the old nebulizer equipment was not stored in a plastic bag.</p> <p>At that time the old equipment was observed to have a light brown debris stuck to the entire inside of the nebulizer mask. LPN #5 indicated the old equipment was not labeled with a date to indicate when the equipment had been changed last. She indicated she was not sure when the nebulizer equipment had been changed.</p> <p>During the administration of the nebulizer treatment, the resident indicated the mask that she had used the last time before this mask did not work because she did not breathe any mist from it when she received her nebulizer treatment.</p>		<p>Manager re-educated the licensed nurses on hand washing, glove use and hand held nebulizers. The DCS/Nurse Manger will re-educate LPN # 6 on hand washing and glove use by October 28, 2014. 4. The Central Supply Clerk/Nurse Manager will conduct QI monitoring of F441 to ensure residents receiving nebulizer treatments have equipment properly labeled and stored. QI monitoring will be conducted five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months using a sample size of five residents receiving nebulizer treatments. The DCS/Central Supply Clerk will report findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring, The DCS/Nurse Manager will conduct QI monitoring of the regulation F441 to ensure proper hand washing and use of gloves. QI monitoring will be conducted via observations across all three shifts five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months alternating shifts using a sample size of three random employees. The DCS/Nurse Manager will report findings to</p>		

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	<p>During an interview on 9/26/14 at 1:10 P.M., the Director of Clinical Services (DCS) indicated he expected the nurses to change the nebulizer equipment when it was ordered to be changed. He indicated he expected the nurses to label the nebulizer equipment with the date it was changed and the equipment to be stored in a labeled bag.</p> <p>2. On 9/25/14 at 11:24 A.M., LPN #6 was observed entering Resident #32's room to complete an accucheck. Prior to starting the procedure she washed her hands for four seconds. She completed the accucheck procedure and removed her gloves. She washed her hands for three seconds.</p> <p>On 9/25/14 at 11:31 A.M., LPN #6 was observed drawing Resident #32's insulin into a syringe, then she went into the resident's room and administered the insulin without gloves. After she gave the insulin she washed her hands for 7 seconds.</p> <p>During an interview on 9/26/14 at 1:10 P.M., the DCS indicated he expected the nursing staff personal to wash their hands for at least 30 seconds. He indicated he expected the nurses to wear gloves when they provided care to residents, handled</p>		two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring, 5. Date of Compliance: October 30, 2014				

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	<p>soiled linen, administered eyedrops and gave injections.</p> <p>3. A current policy titled "Hand Held Nebulizer (Small Volume Nebulizer)" dated 01/01/2009, provided by the Regional Director of Clinical Services on 9/29/14 at 10:53 A.M., indicated "...Procedure: ...3. Follow infection control procedures as appropriate...16. Disassemble device and rinse the mouthpiece and nebulizer cup with water and dry. Place entire unit in a bag to be maintained in the resident's room...."</p> <p>A current policy titled "Hand Washing Technique" dated 09/01/2011, provided by the Regional Director of Clinical Services on 9/29/14 at 10:53 A.M., indicated "...Procedure: ...6. Rub hands together vigorously for 10-15 seconds, generating friction on all surfaces of the hands and fingers. Friction removes more surface organisms than either soap or water, so always scrub briskly...."</p> <p>A current policy titled "Standard Precautions" dated 09/01/2011, provided by the Director of Clinical Services on 9/30/14 at 9:30 A.M., indicated "Policy...Standard Precautions apply to blood, all body fluids, secretions and excretions except sweat, regardless of whether or not they contain visible blood,</p>			

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F000465 SS=F	<p>non-intact skin, and mucous membranes...."</p> <p>3.1-18(l)</p> <p>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 and interview, the facility failed to ensure floors were clean and in good repair throughout the building. This deficient practice had the potential to affect 71 of 71 resident residing in the building.</p> <p>Findings include:</p> <p>The environmental tour was conducted with the Housekeeping and Maintenance Supervisors on 09/25/2014 at 1:25 P.M.</p> <p>During the tour the following was observed:</p> <p>a. The 100 and 200 unit hallway floors had a build up of dirt and debris spanning 1/2 to 1 inch from the cove board and walls and the cove board had a build up of dirt and debris.</p>	F000465	<p>F-465</p> <p>1. The 100 and 200 hallway floors will be scraped and cleaned by October 28, 2014. The corner floors of the 6 sets fire doors will be scraped and cleaned by October 28, 2014. The door entry threshold trim for rooms 109, 115, 206, 207, and 216 will be scraped and cleaned by October 28, 2014.</p> <p>2. All residents have the potential to be affected by this alleged deficient practice.</p> <p>3. The Housekeeping Supervisor will re-educate the housekeeping staff on daily</p>	10/30/2014

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	<p>b. In the corners on the floor of the residents' doorways there was a build up of dirt and debris.</p> <p>c. In the corners on the floor of the 6 sets of fire doors there was a buildup of dirt and debris.</p> <p>d. The floor around the base of the 100 and 200 unit nursing stations had a build up of dirt and debris.</p> <p>e. The door entry threshold trim was broken or missing in rooms 109, 115, 206, 207, and 216.</p> <p>During an interview at this time, the Housekeeping Supervisor indicated he was aware the floors were not clean. He indicated the buffer did not reach the edges, so they were not clean as they should be.</p> <p>3.1-19(f)</p>		<p>mopping of rooms, lounges, hallways, the 5 &amp; 7 Step Deep Cleaning Procedures, emphasis will be placed on corners and edges of rooms and entrances.</p> <p>The Maintenance Director will replace cove moldings by 10/29/14.</p> <p>4. The Housekeeping Supervisor/ED will conduct QI monitoring of F465 to ensure the floors are clean and in good repair. QI monitoring will be conducted via observation five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months using a sample size of three random residents and a hallway. The Housekeeping Supervisor/ ED will report findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring,</p> <p>5. Date of Compliance: October 30, 2014</p>				

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F000520 SS=E	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on interview and record review, the facility failed to identify repeat non-compliance issues related to fall care plans not followed. In addition the facility failed to investigate behaviors and falls needing interventions for wandering residents. This deficient practice affected 1 of 3 residents reviewed for falls and 3 of 3 residents reviewed for behavior care and interventions. (Residents #66, #33, #57 and #47).</p>	F000520	<p>F-520</p> <p>1. Resident # 66 and 57 no longer reside in the facility. Resident # 33 was placed on 1:1 supervision until discharged to the hospital on 9/27/14. Resident #33 returned, status post hospital stay and medication adjustment. Resident currently on increased supervision. The IDT will review the care plan, nurse tech kardex and physician's orders for resident #47 by 10/24/14</p>	10/30/2014

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	<p>Findings include:</p> <p>During an interview on 9/25/14 at 3:02 P.M., the Administrator indicated the "Biggest" ID (identified) quality concern was regarding continuity of care. He planned to use marketing, and complete orientation of the staff. In their QA (Quality Assurance) meetings they discussed at risk residents or residents with acuity changes. No specific quality improvement projects were mentioned.</p> <p>On 9/25/2014 at 5:20 P.M., an Immediate Jeopardy situation was identified and a notification was given to the facility as a result of the facility's lack of monitoring and supervising Resident #66. In addition, the facility failed to identify and follow up for wandering and intrusive behaviors of Residents #33 and #57.</p> <p>Record review and interview, indicated the facility failed to identify the lack of fall care plan updates for Resident #47. In addition, the facility had failed to follow fall care plans for Resident #66. Both Residents had falls that resulted in injury.</p> <p>The record of the facility's, "Performance Improvement Committee (Quality Assurance)" dated with a revision date of 3/7/2014 was reviewed on 9/29/2014 at</p>		<p>to ensure fall preventative interventions are in place.</p> <p>2. All residents have the potential to be affected by this alleged deficient practice. The care plan, Nurse Tech Kardex, and physician's orders for residents who had fallen in the last 30 days were reviewed by the Falls Committee on 10/08/14 to ensure appropriate fall interventions were in place. Any issues identified were corrected immediately. A behavioral management meeting will be held by the IDT to identify targeted behaviors and ensure non-pharmacological interventions for wandering residents by October 28, 2014.</p> <p>3. The RDSCS will re-educate the Department Heads on the regulation F520 and the facility's Performance Improvement Committee policy by October 28, 2014. An Ad-Hoc Quality Assurance/Performance Improvement Meeting was held with the ED, DCS, Medical Director and 3 additional staff members on 9-25-14 to review the Facility's policies and procedures for Behavior</p>	

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	<p>10:34 A.M. The record indicated the, "Performance Improvement Committee will meet monthly to review, recommend and act upon activities of the facility, performance action teams and / or department activities. The committee shall direct all activities including approving proposed monitoring, evaluating and review of services...."</p> <p>3.1-52(b)(2)</p>		<p>Management, Behavior Monitoring, Incident and Accident Reporting, and Abuse Reporting and Investigation Process. The policies and procedures were adopted by the facility without changes.</p> <p>4. The Regional Vice President of Operations (RVPO)/ RDCS will monitor the QAPI the monthly for three months to ensure substantial compliance. A member of the regional team will attend two quarterly QAPI committee meetings.</p> <p>5. Date of Compliance: October 30, 2014</p>		