

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 08/23/2013
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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.</p> <p>Survey dates: August 18, 19, 20, 21, 22, and 23, 2013</p> <p>Facility number: 000336 Facility number: 155376 AIM: 100290170</p> <p>Survey team: Janet Stanton, R.N.--Team Coordinator Michelle Hosteter, R.N. Gloria Bond, R.N. Sandra Nolder, R.N.</p> <p>Census bed type: SNF/NF--65 Total--65</p> <p>Census payor type: Medicare--5 Medicaid--46 Other--14 Total--65</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review was completed by Tammy Alley RN on August 29, 2013.</p>	F000000		
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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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F000241 SS=E	<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, interview and record review the facility failed to ensure residents were treated with dignity and had gait belts removed after being transferred for 6 of 33 residents who met the criteria for dignity. (Residents # 17, # 32, # 36, # 50, # 56, and # 63)</p> <p>Findings include:</p> <p>1. Resident # 36 was observed wearing a gait belt on these dates and times:</p> <p>On 8/19/13 at 10:20 A.M., the resident was observed with a gait belt around her waist. She had been pulling on the gait belt while sitting in her recliner.</p> <p>On 8/19/13 at 1:30 P.M., the resident was observed with a gait belt around her waist sitting in her recliner.</p> <p>On 8/20/13 at 9:30 A.M., the resident was observed with a gait belt around her waist sitting in her recliner</p>	F000241	<p>I. Residents #17,32,36,50,56 & 63 were assessed for appropriateness of removing gait belt after transfer. The care plan and Care Tracker updated with resident specific instructions for gait belt use. II. All residents have the potential to be affected. Any resident that required assistance with transfer were assessed for appropriateness of removing gait belt after transfer. The care plan and care tracker updated with resident specific instructions for gait belt use. III. Education provided to nursing staff on dignity related to gait belt removal. All residents requiring assistance with transfer will be reviewed on admission and quarterly in the care plan meeting to determine appropriateness of removing gait belt after transfer. The care plan and care tracker will be updates as indicated. IV. Nursing Staff responsible SSD to monitor. Social service Designee will complete the Dignity Performance Improvement tool every week for four weeks then monthly to ensure that residents were treated with dignity and had gait belts removed after transfer as appropriate. The Dignity</p>	09/22/2013	

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	<p>On 8/20/13 at 2:15 P.M., the resident was observed with a gait belt around her waist sitting in her recliner</p> <p>On 8/21/13 at 9:50 A.M., the resident was observed sitting in her wheelchair with a gait belt around her waist and she was trying to get up out of her wheelchair.</p> <p>On 8/21/13 at 2:25 P.M., the resident had a gait belt on around her breast area sitting in her wheelchair in her room.</p> <p>On 8/22/13 at 10 A.M., the resident had a gait belt on around her breast area sitting in her wheelchair in the South hallway.</p> <p>2. On 8/21/13 at 12:27 P.M., 4 of 27 residents in the main dining room had gait belts around their waist areas while eating their lunch. (Residents # 36, # 50, # 56 and # 63)</p> <p>3. On 8/21/13 at 12:27 P.M., 1 of 27 residents in the main dining room, Resident #17, had a gait belt around her breast area while eating her lunch.</p> <p>On 8/21/13 at 1:13 P.M., Resident #17 was observed to be transported</p>		Performance Improvement tool will be submitted to the monthly QAPI meeting for review. V. September 22, 2013		

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	<p>out of the main dining room, and positioned in her wheelchair outside of her room with the gait belt around her breast area.</p> <p>On 8/21/13 at 1:30 P.M., the resident was transported to her room and the gait belt was around her breast area.</p> <p>On 8/21/13 at 2:15 P.M., the resident was lying in bed with the gait belt around her breast area.</p> <p>4. Resident # 63 was observed on 8/21/13 at 1:25 P.M., sitting in a recliner in the North T.V. lounge with a gait belt on around her breast area.</p> <p>5. Resident # 50 was observed on 8/21/13 at 2:15 P.M., lying in bed with her gait belt on around her waist.</p> <p>6. Resident # 32 was observed on 8/22/13 at 9:55 A.M., sitting in the South hallway in his merry walker with the gait belt on around his waist.</p> <p>7. During an interview on 8/21/13 at 2:30 P.M., CNA # 13 indicated she was unsure of the gait belt policy, but she would check on it. She indicated she would normally take off the gait belt to place a resident in the bed. She indicated she did not place Resident # 50 in the bed, but she did</p>			

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	<p>place Resident # 17 in the bed with the gait belt on. She indicated the proper placement for the gait belt was around the waist. She removed the gait belt from around Resident # 17's breast area.</p> <p>During an interview on 8/21/13 at 2:34 P.M., CNAs # 3 and 4 indicated the gait belt policy was not specific whether the gait belts were to be left on or taken off after transfers were completed. They indicated the policy said it was according to the resident's needs and what the residents prefer. CNA # 4 indicated the proper positioning for the gait belt was under the breasts. Both CNA # 3 and # 4 indicated there should be two fingers comfort for the gait belt. They indicated therapy instructed them on the proper positioning of the gait belt.</p> <p>During an interview on 8/21/13 at 3:30 P.M., the Assistant Director of Nursing (ADON) indicated the facility was cited recently for the use of gait belts. She indicated a resident was falling and the staff pulled on the resident's pants and the facility was cited. She did not have any comment for the gait belts found around the resident's breast areas.</p> <p>On 8/21/13 at 3:30 P.M., the ADON</p>				

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	<p>provided a Policy/Procedure titled "Gait Belt Transfer," and dated effective on 1/1/07. The procedure indicated the belt was to be placed around the resident's waist, snug but not tight. The ribs, hipbones or breasts were to be avoided. There was no instructions to leave the gait belt on at all times.</p> <p>During an interview on 8/22/13 at 3:15 P.M., the ADON indicated residents who were transferred with a mechanical lift would not need to have gait belts on for transfers.</p> <p>The "Resident Profile Report" current on 8/22/13 for Resident # 17, indicated the resident was to be transferred with a Hoyer (mechanical) lift for transfers. It indicated the Sara (stand-up) lift was not to be used for transfers.</p> <p>3.1-3(t)</p>			

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F000242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a bath tub was available to 1 resident who desired a tub bath, in a sample of 4 residents reviewed for choices and preferences that were important to them. (Resident # 67)</p> <p>Findings include:</p> <p>In an interview on 8/19/13 at 11:02 A.M., Resident #67 indicated she would like to have a tub bath. She indicated that no one had ever asked if she would like a tub bath. The MDS (Minimum Data Set) assessment, dated 5/8/13, indicated the resident found it somewhat important to choose between a shower and a tub bath.</p> <p>In an interview on 8/19/13 at 9:51 A.M., the Maintenance Director indicated there was no communal bath tub available in the facility. Several resident rooms had bath tubs</p>	F000242	<p>I. Resident #67 was interviewed on 9/10/13 and informed her we had plans to obtain a tub for bathing. II. The Activity Director interviewed all residents with BIMS > than 8 to obtain preference of a tub bath or shower. Anone preferring a tub bath were informed of a plan to obtain a tub. III. The Administrator submitted a capital expenditure to purchase a bath tub. Education provided to staff on resident right to choose. All cognitively intact residents will be asked on admission and quarterly on preference related to bathing by SSD or designee, ensuring resident right to choose. IV. The Activity Director will complete the Free Choice & Rights Performance Improvement tool every month x 3 months then quarterly. The Free Choice and Rights Performance improvement tool will be submitted to the monthly QAPI meeting for review. V. 9/22/13 for response to request to purchase. 10/22/13 for delivery and installation of tub bath due to construction.</p>	09/22/2013			

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	<p>in the bathroom, but they were not really fitted to be handicap accessible. He didn't believe they had ever been used.</p> <p>In an interview on 8/22/13 at 3:20 P.M., the ADON (Assistant Director of Nursing) indicated they have never offered residents a bath option because they do not have a tub bath. She indicated they ask upon admission regarding choices of days or evenings and showers, but never ask regarding taking a tub bath.</p> <p>On 8/22/13 at 3:30 P.M., all resident rooms and the two communal shower rooms in the facility were observed. There were no tub in either shower room or any resident rooms except for rooms 217, 218, 219, and 220. Those rooms had a low, regular bath tub in the bathroom.</p> <p>3.1-3(u)(3)</p>			

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F000279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to develop Care Plans and/or appropriate interventions/approaches to address issues of skin care, bruising, non-compliance with a personal alarm, or behaviors, for 4 of 27 residents reviewed for Care Plans. In addition, the facility failed to develop a coordinated Care Plan with a Hospice agency that identified which provider (hospice or facility) was responsible for various aspects of care, for 1 of 1 resident who was receiving Hospice services.</p>	F000279	I. Care Plan Team will meet to redevelop care plans of residents identified. II. All care plans will be reviewed and corrected as needed. III. There will be education provided for the entire team on developing care plans, appropriate interventions/approaches to address issues of skin care, bruising and non compliance with a personal alarm or behaviors. In addition education on developing, monitoring complications, risk factors, care area triggers. The MDS coordinator will ensure current care area triggers are included in the care plan. An	09/22/2013

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	<p>(Residents #32, #83, #86, #87, and #42)</p> <p>Findings include:</p> <p>1. The record for Resident #86 was reviewed on 8/21/13 at 9:15 A.M. An acute care hospital progress note, dated 4/29/13, indicated resident had become more confused over the week-end and was now actively hallucinating. Diagnoses at that time included, but were not limited to, rhabdomyolysis, acute kidney failure, metabolic encephalopathy, depression and anxiety. A hospital Social Service progress note, dated 5/1/13, indicated the resident's primary diagnosis was dementia with a subsequent resolution of her psychosis.</p> <p>Physician orders upon admission 5/1/13 included Clonazepam (Klonopin--an anti-convulsant also used as a mood stabilizer), Risperdal (an anti-psychotic), Wellbutrin (an antidepressant), and Risperdal PRN (as needed) for severe agitation.</p> <p>A consultant psychiatric evaluation report, dated 5/23/13, indicated the Risperdal was to be decreased to 0.5 mg. (milligrams) twice a day for 2 weeks, then decreased to 0.5 mg.</p>		<p>outside MDS coordinator will review a minimum of one care plan weekly that was reviewed by the team. Looking for appropriate signs, symptoms, issues, needs, causes preferences, complications, strengths, risk factors, current care area triggers and interdisciplinary review. IV. Care plan team responsible, MDS coordinator to monitor and report to QAPI monthly. V. 9/22/13</p>				

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	<p>every morning for 2 weeks, then discontinued.</p> <p>A nurse's progress note, dated 7/1/13 at 3:45 P.M., indicated "Contacted physician regarding resident complains of being 'jittery' since discontinuing Risperdal. Will await return call." A note on 7/2/13 at 9:00 A.M. indicated "New order [for] Risperdal 0.5 mg. po (by mouth) QD (every day) related to agitation...."</p> <p>A nurse's progress note, dated 8/5/13 at 5:40 P.M., indicated the facility had received a call from the Veteran's Administration Hospital suicide hotline, reporting that Resident #86 had placed a call to them threatening to kill herself. The attending physician, family, and consultant psychiatrist were notified, and the resident was sent emergently to the hospital for an evaluation and treatment.</p> <p>A hospital psychiatric consultation report, dated 8/5/13, indicated the resident had been "distracted" about a financial situation which she felt nobody at the facility wanted to listen to or try to help her resolve. The report indicated the resident called the hotline because she just needed someone to talk to. The consultant</p>			

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	<p>indicated the resident stated she has had suicidal ideation a few times during her life, but never had a plan or intent. The resident reported she had made her comments "in the heat of the moment," and was not genuinely sure if she meant it, but doubted she said it specifically for the attention of the staff. The resident indicated those emotions were very short lived and she had no real intent to act on those feelings.</p> <p>One Care Plan entry for "Mood State" addressed issues of: 5/14/13--History of depression and anxiety, victim of spousal emotional abuse, recently psychotic; 5/23/13--resolving delirium, recurrent depression; 8/5/13--Psychiatric Emergency Room, verbalized suicidal ideation.</p> <p>The approaches/interventions were listed as: 5/1/13--Psychiatric evaluation, psychotherapy referral; 8/5/13--Psychiatric Emergency Room, Clonazepam 0.5 mg. twice a day, Wellbutrin SR 100 mg. twice a day, Risperdal 0.5 mg. daily.</p> <p>A Care Plan entry for "Psychosocial" addressed an issue of : 5/14/13--Resident is newly admitted with</p>			

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	<p>potential for maladjustment. The approaches/interventions were listed as: 5/1/13--Introduce self; tour facility as needed; encourage out of room activities; encourage socialization; monitor for mood changes; encourage family visits; maintain customary routine.</p> <p>In an interview on 8/23/13 at 2:27 P.M., the MDS (Minimum Data Set) Coordinator indicated she created the basic format for the hand-written Care Plans and formulated the entries for Nursing. The other disciplines wrote their own. Social Service was supposed to enter approaches/interventions in the Care Tracker computer system for the CNAs; however, other departments, such as Activities and Nursing, could also add approaches to the Care Tracker system. There was no one person who oversees the coordination of all care planning information. For her part, she tried to make sure the problems and approaches in the paper Care Plan were individualized for each resident.</p> <p>The Care Tracker system "Resident Profile Report" for Resident #86, current as of 8/22/13, included the following: Up with assist; resident to use long-handled reacher as needed;</p>						

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	<p>use gait belt for assist with ambulation or transfers; resident to use single pod cane; regular diet.</p> <p>Approaches/interventions specific to identifying and assisting the resident to deal with her anxiety, frustration, episodes of suicidal ideation thoughts, and psychological issues were not found.</p> <p>2. The record for Resident #83 was reviewed on 8/22/13 at 10:45 A.M. An acute care hospital consultant psychiatrist discharge summary report, dated 5/16/13, indicated the resident had diagnoses that included, but were not limited to, dementia-probably vascular/mixed (vascular/Alzheimer's) with mood lability, anxiety and disturbance of behavior, psychosis due to illness, recent delirium due to poorly controlled diabetes, and urinary infection.</p> <p>A Care Plan for "Mood State" addressed issues of: 4/4/13 and 6/13/13--History of anxiety, restlessness.</p> <p>The approaches/interventions were listed as: Psychiatric evaluation and Rx. (prescription medications); psychotherapy evaluation and Rx.</p>						

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	<p>A Care Plan for "Psychotropic Medication use" addressed an issue of : 4/4/13--tendency to anxiety, restlessness.</p> <p>The approaches/interventions were listed as: 4/3/13--GDR (gradual dose reduction) attempt every 6 months; monitor medication side effects; monitor symptoms; 5/28/13--No GDR at this time--Seroquel (an antipsychotic medication); current symptoms controlled, lowest effective dose; Diagnosis dementia with behavior disturbance; 6/5/13--Seroquel 50 mg. (milligrams) twice a day; 6/11/13--Psychiatric evaluation and treatment.</p> <p>In an interview on 8/23/13 at 2:27 P.M., the MDS (Minimum Data Set) Coordinator indicated she created the basic format for the hand-written Care Plans and formulated the entries for Nursing. The other disciplines wrote their own. Social Service was supposed to enter approaches/interventions in the Care Tracker computer system for the CNAs; however, other departments, such as Activities and Nursing, could</p>						

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	<p>also add approaches to the Care Tracker system. There was no one person who oversees the coordination of all care planning information. For her part, she tried to make sure the problems and approaches in the paper Care Plan were individualized for each resident.</p> <p>The Care Tracker system "Resident Profile Report" for Resident #83, current as of 8/22/13, included the following: Explain inappropriateness of behavior; allow for safe wandering; Foley catheter--empty every shift, check leg bag every shift, patient takes it off; black (dignity) bag cover on both sides of bed; use memory scripts in room, clock and calendar when confused; encourage fluids; check bathroom after resident/can be incontinent of bowel at times; wanderguard at all times; report noted changes in urine to nurses; resident has Foley catheter--at times will open to empty bag, and does not close cap; check for dryness of clothing and shoes; uses pad for bowel incontinence; resident has short-term memory--will forget he has went (sic) to bathroom.</p> <p>Approaches/interventions specific to identifying behaviors requiring use of an anti-psychotic medication and</p>			

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	<p>assisting the resident manage those issues were not found.</p> <p>3. The record for Resident #42 was reviewed on 8/21/13 at 2:38 P.M. Diagnoses included, but were not limited to, dementia with behavior disturbance, hypothyroidism, leukocytosis, vascular dementia with depression, anxiety disorder, hypertension, history of myocardial infarction (heart attach), cardiomegaly, cerebral atherosclerosis, and gastro-intestinal reflux disease.</p> <p>The August, 2013 physician order recap (recapitulation) sheet listed an order for: 3/1/13--(Name of the Hospice agency)</p> <p>The facility Care Plan "Interdisciplinary Participation" sign in sheet indicated reviews of the Care Plan for Resident #42 were done on 4/22, 5/9, and 8/1/13. There were no signatures from any of the Hospice agency personnel.</p> <p>The facility Care Plan had 28 entries addressing issues of psychosocial, cognition, visual function, communication, ADL: Hygiene and Dress, Mobility, Genitourinary,</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>Behaviors, Activities, Fall Risk, Nutrition, Fluid Maintenance, Oral Care, Pressure Ulcer Prevention, Psychotropic Medication, Discomfort and Pain, Pain Medication, Upper Gastrointestinal, Lower Gastrointestinal, Hypothyroidism, Hyperlipidemia, Blood Dyscrasia, Cardiovascular, Hospice, Respiratory, Elopement Risk, Skin, and Right thumb fracture (11/12).</p> <p>The facility disciplines or "Department responsible for approach" were listed as N, D, S (Nursing, Dietary, Social Service), or All (facility staff).</p> <p>The facility Care Plan entry for "Hospice," dated 1/11/12, addressed "Resident receiving terminal care due to dementia by (name of Hospice Agency) since October 2011- -discontinued 10/12. Resident with (the same Hospice agency, but renamed) 10/12.</p> <p>The approaches listed were for "N" department of the facility, and indicated "See care plans specific to symptoms. Communicate with Hospice providers at every opportunity. Invite hospice providers to care reviews." The Care Plans "specific to symptoms" did not refer to the Hospice service or describe which</p>			

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	<p>services were to be provided by the facility and which services were to be provided by the Hospice agency, or identifying who was responsible for the various aspects of care.</p> <p>The Hospice agency Care Plan was dated as starting on 10/20/12, and signed by the Hospice disciplines as reviewed by them on 7/24, 7/25, 7/30, and 7/31/13. There were 13 problem areas identified, with interventions to be implemented by the Hospice skilled nurse, social worker, home health aide, or chaplain. The Hospice Care Plan did not identify which services were to be provided by the facility and which services were to be provided by the Hospice agency, or who was responsible for the various aspects of care.</p> <p>In an interview on 8/22/13 at 1:20 P.M., LPN #12 indicated the Hospice HHA (Home Health Aide) came "maybe" three times a week, early in the morning. The HHA just did basic care for the resident (a shower or bed bath, a shampoo as needed, nail care as needed). She indicated the Hospice nurse came "maybe" once a week, but it was usually in the evening. She didn't see the nurse very often, and when she did, the nurse just asked if she needed</p>				

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	<p>anything. LPN #12 indicated she usually didn't need anything because she had already called the Hospice office. She indicated she and the CNA's had not participated in any of the Care Planning, which was done by the administrative staff. She indicated the resident has continued on Hospice since 2011 because of episodic weight loss issues.</p> <p>4. The record review for Resident #32 was reviewed on 8/23/13 at 9 A.M.</p> <p>Current diagnoses included, but were not limited to, dementia with behavior disturbances, diabetes mellitus type 2, anemia, and difficulty in walking.</p> <p>A review of the resident's skin integrity sheet dated 8/16/13 and 8/23/13 indicated the resident's skin was without any marks or open areas.</p> <p>On 8/19/13 at 2:46 P.M., the resident was observed to have a red colored bruise to his left upper arm, with two red colored bruises on his left forearm. A Band-Aid was covering an area on his left upper arm.</p> <p>On 8/23/13 at 11:50 A.M., LPN # 9 indicated the resident had bruises to</p>				

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	<p>his bilateral arms. She removed the Band-Aid covering the area to the resident's left upper arm and indicated the resident had a scabbed skin tear that measured 1.5 x 0.5 centimeters.</p> <p>Resident # 32's clinical record lacked a care plan to address bruises and a skin tear.</p> <p>5. The record review for Resident # 87 was completed on 8/22/13 at 11 A.M. Diagnoses included, but not limited to, high blood pressure, restless leg syndrome and arthritis, and a history of falls.</p> <p>In an interview on 8/20/13 9:56 A.M., LPN #12 indicated Resident # 87 had a fall last week in the restroom, and sustained a laceration to the back of her head.</p> <p>The "Resident Profile Sheet," dated 8/22/13, indicated "...BED ALARM WHILE IN BED-CHECK...."</p> <p>On 8/23/13 at 9:05 A.M., the resident was observed out of bed and in her recliner. The pressure alarm pad was observed to be in the bed underneath her sheet.</p>				

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	<p>In an interview on 8/23/13 at 9:10 A.M., the resident indicated her legs were very restless this morning, and the Tylenol that LPN #1 had given her didn't really help. She indicated her legs are really giving her "fits."</p> <p>In an interview on 8/23/13 at 9:13 A.M., LPN #1 indicated the resident had been getting out of bed into the chair independently prior to today. At 9:15 A.M., LPN # 1 told the resident that her chair alarm should be moved from her bed to her recliner. He told the resident when she gets up from bed she needs to let staff know so they can move the alarm for her. Resident # 87 indicated she knew she should do that because she had been falling.</p> <p>The Fall care plan, dated 8/14/13, indicated "...bed alarm, non slip foot wear, call light in reach, verbal cues for safety. 8/15/13--Steri strips (adhesive laceration closures) to side of head every shift for 5 days...."</p> <p>The nurses notes dated 8/16/13 and 8/17/13 indicated the resident was self-transferring to bathroom, and staff reminded her she needed to call them when she decided to get up because she required assistance to transfer.</p>						

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	<p>There was nothing documented on the care plan regarding self-transfer attempts and the need to notify staff when she got up.</p> <p>3.1-35(a)</p>			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to follow the Care Plan for fall interventions, related to the use of an alarm, for 1 of 27 residents reviewed for following care plans. (Resident #87)</p> <p>Findings include:</p> <p>The record review for Resident # 87 was completed on 8/22/13 at 11 A.M. Diagnoses included, but not limited to, high blood pressure, restless leg syndrome and arthritis, and a history of falls.</p> <p>In an interview on 8/20/13 9:56 A.M., LPN #12 indicated Resident # 87 had a fall last week in the restroom, and sustained a laceration to the back of her head.</p> <p>The "Resident Profile Sheet," dated 8/22/13, indicated "...BED ALARM WHILE IN BED-CHECK...."</p> <p>On 8/23/13 at 9:05 A.M., the resident was observed out of bed and in her recliner. The pressure alarm pad was</p>	F000282	<p>I. Care Plan Team will meet and develop care plan for residents identified of deficient practice. II. All care plans will be reviewed and corrected as indicated. III. Education for the care plan team will be provided to insure appropriate interventions, resolutions and additional goals as indicated. Unit Managers will ensure identified areas are added to care plan and resident profile. An outside MDS coordinator will review one care plan per week to ensure care areas are addressed. The MDS coordinator will print Resident Profile Report for evaluation with care plan during quarterly review. IV Care Team responsible, outside MDS coordinator and MDS coordinator to monitor. Results and progress reported to the QA/QI monthly. V 9/22/13</p>	09/22/2013			

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	<p>observed to be in the bed underneath her sheet.</p> <p>In an interview on 8/23/13 at 9:10 A.M., the resident indicated her legs were very restless this morning, and the Tylenol that LPN #1 had given her didn't really help. She indicated her legs are really giving her "fits."</p> <p>In an interview on 8/23/13 at 9:13 A.M., LPN #1 indicated the resident had been getting out of bed into the chair independently prior to today. At 9:15 A.M., LPN # 1 told the resident that her chair alarm should be moved from her bed to her recliner. He told the resident when she gets up from bed she needs to let staff know so they can move the alarm for her. Resident # 87 indicated she knew she should do that because she had been falling.</p> <p>The Fall care plan, dated 8/14/13, indicated "...bed alarm, non slip foot wear, call light in reach, verbal cues for safety. 8/15/13--Steri strips (adhesive laceration closures) to side of head every shift for 5 days...."</p> <p>The nurses notes dated 8/16/13 and 8/17/13 indicated the resident was self-transferring to bathroom, and staff reminded her she needed to call</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>them when she decided to get up because she required assistance to transfer.</p> <p>3.1-35(g)(2)</p>			

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review, the facility failed to ensure the skin was monitored, and orders for treatment were obtained, for non-pressure skin conditions, for 2 of 4 residents reviewed for Non-pressure Skin Conditions. In addition, the facility failed to develop a coordinated Care Plan with a Hospice agency that identified which provider (hospice or facility) was responsible for various aspects of care, for 1 of 1 resident who was receiving Hospice services. (Resident #32, #88, and #42)</p> <p>Findings include:</p> <p>1. The record review for Resident #88 was reviewed on 8/22/13 at 1:35 P.M. Current diagnoses included, but were not limited to, diabetes mellitus, convulsions, chronic kidney disease and frontotemporal dementia syndrome.</p>	F000309	<p>I. On 8./22/13 a skin integrity review was completed for resident #88 noting bruising on bilateral hands. Non pressure skin condition records were initiated. The physician was notified with no new orders noted. On 8/23/13 a skin integrity review was completed for resident #32 noting bruising and a skin tear on left upper extremity. Non pressure skin condition records were initiated. The physician was notified with new treatment order received. The licensed nurse that completed the weekly skin integrity review dated 8/23/13 and licensed nurse that completed the weekly skin integrity review dated 8/23/13 noted the skin was intact, was given an employee corrective action. Harbor Light Hospice was contacted by the Administrator to ensure care plan meetings were attended and coordination of care was outlined. II. The DCS or designee completed a skin integrity review for all residents. The physician was notified of any noted skin conditions and new orders were obtained as indicated. Non pressure skin</p>	09/22/2013	

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	<p>A review of the skin integrity review sheets dated 8/16/13, with the Assistant Director of Nursing (ADON) indicated the resident's skin was without any marks or open areas.</p> <p>A review of the resident's Care Plan, dated 8/13/13, for pressure sores/skin care indicated a goal to prevent and heal pressure sores and skin breakdown. It indicated interventions were to follow the facility skin care policy.</p> <p>On 8/20/13 at 11:12 A.M., the resident was observed to have had a purple and red colored bruise on top of his bilateral hands.</p> <p>During an observation on 8/22/13 at 3:15 P.M., with the Assistant Director of Nursing (ADON) in attendance, a purple colored bruise to the top of the resident's bilateral hands was observed.</p> <p>The ADON indicated the resident's skin was to be reassessed and the skin review sheet was to be updated tonight, but she was going to have the resident's nurse assess the bruises to his bilateral hands at this time and update the sheet.</p> <p>2. The record for Resident #32 was</p>		<p>condition records were initiated on all noted skin conditions. III. Licensed Nurses were educated on skin assessment and treatment. The DCS or designee will complete a random skin integrity review on 4 residents weekly on the day after the night shift completes a weekly skin review. The DCS or designee will ensure the review was completed and documented correctly in the medical record. The DCS or designee will initial the weekly skin integrity review after verifying its accuracy. If there is noted discrepancy the DCS or designee will complete a new entry on the weekly skin review, initiate the skin record and notify the physician for treatment orders as indicated. All hospice companies will be required to attend the facility care plans for their perspective patient. If attendance is not attended a breach of contract could be utilized. IV. Licensed Nurses responsible, DCS or designee will monitor and reported monthly at QAPI</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 08/23/2013
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>reviewed on 8/23/13 at 9 A.M. Current diagnoses included, but were not limited to, dementia with behavior disturbances, diabetes mellitus type 2, anemia, and difficulty in walking.</p> <p>A review of the skin integrity sheet dated 8/16/13 and 8/23/13 indicated the resident's skin was without any marks or open areas.</p> <p>On 8/19/13 at 2:46 P.M., the resident was observed to have a red colored bruise to his left upper arm with two red colored bruises on his left forearm and a Band-Aid covering an area on his left upper arm.</p> <p>During an interview on 8/23/13 at 11:50 A.M., LPN # 9 indicated the resident had bruises to his bilateral arms. She removed the Band-Aid covering the area to the resident's left upper arm and indicated the resident had a scabbed skin tear that measured 1.5 x 0.5 centimeters.</p> <p>3. During an interview on 8/22/13 at 2:45 P.M., the ADON indicated the procedure for reporting skin abnormalities was for the CNA's to fill out two pink skin report sheets. One was given to the management staff and one was given to the resident's nurse. She indicated the resident's</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>nurse would update the resident's skin integrity review sheet. She indicated these sheets were updated weekly by the nurses.</p> <p>The policy and procedure for "Wound Care: Non-Pressure Skin Condition Record" dated 1/1/07 was provided by the ADON on 8/23/13 at 9:45 A.M. The policy indicated each resident had a non-pressure ulcer skin condition record completed for each skin abnormality and each week the non-pressure ulcer skin abnormality was to be assessed and the form was to be completed.</p> <p>4. The record for Resident #42 was reviewed on 8/21/13 at 2:38 P.M. Diagnoses included, but were not limited to, dementia with behavior disturbance, hypothyroidism, leukocytosis, vascular dementia with depression, anxiety disorder, hypertension, history of myocardial infarction (heart attach), cardiomegaly, cerebral atherosclerosis, and gastro-intestinal reflux disease.</p> <p>The August, 2013 physician order recap (recapitulation) sheet listed an order for: 3/1/13--(Name of the Hospice</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>agency)</p> <p>The facility Care Plan "Interdisciplinary Participation" sign in sheet indicated reviews of the Care Plan for Resident #42 were done on 4/22, 5/9, and 8/1/13. There were no signatures from any of the Hospice agency personnel.</p> <p>The facility Care Plan had 28 entries addressing issues of psychosocial, cognition, visual function, communication, ADL: Hygiene and Dress, Mobility, Genitourinary, Behaviors, Activities, Fall Risk, Nutrition, Fluid Maintenance, Oral Care, Pressure Ulcer Prevention, Psychotropic Medication, Discomfort and Pain, Pain Medication, Upper Gastrointestinal, Lower Gastrointestinal, Hypothyroidism, Hyperlipidemia, Blood Dyscrasia, Cardiovascular, Hospice, Respiratory, Elopement Risk, Skin, and Right thumb fracture (11/12).</p> <p>The facility disciplines or "Department responsible for approach" were listed as N, D, S (Nursing, Dietary, Social Service), or All (facility staff).</p> <p>The facility Care Plan entry for "Hospice," dated 1/11/12, addressed "Resident receiving terminal care due</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>to dementia by (name of Hospice Agency) since October 2011- -discontinued 10/12. Resident with (the same Hospice agency, but renamed) 10/12.</p> <p>The approaches listed were for "N" department of the facility, and indicated "See care plans specific to symptoms. Communicate with Hospice providers at every opportunity. Invite hospice providers to care reviews." The Care Plans "specific to symptoms" did not refer to the Hospice service or describe which services were to be provided by the facility and which services were to be provided by the Hospice agency, or identifying who was responsible for the various aspects of care.</p> <p>The Hospice agency Care Plan was dated as starting on 10/20/12, and signed by the Hospice disciplines as reviewed by them on 7/24, 7/25, 7/30, and 7/31/13. There were 13 problem areas identified, with interventions to be implemented by the Hospice skilled nurse, social worker, home health aide, or chaplain. The Hospice Care Plan did not identify which services were to be provided by the facility and which services were to be provided by the Hospice agency, or who was responsible for the various</p>			

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	<p>aspects of care.</p> <p>In an interview on 8/22/13 at 1:20 P.M., LPN #12 indicated the Hospice HHA (Home Health Aide) came "maybe" three times a week, early in the morning. The HHA just did basic care for the resident (a shower or bed bath, a shampoo as needed, nail care as needed). She indicated the Hospice nurse came "maybe" once a week, but it was usually in the evening. She didn't see the nurse very often, and when she did, the nurse just asked if she needed anything. LPN #12 indicated she usually didn't need anything because she had already called the Hospice office. She indicated she and the CNA's had not participated in any of the Care Planning, which was done by the administrative staff. She indicated the resident has continued on Hospice since 2011 because of episodic weight loss issues.</p> <p>3.1-37(a)</p>				

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F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>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 ensure a pressure wound was accurately assessed, for 1 of 5 residents reviewed for Pressure Wounds. (Resident #47)</p> <p>Findings include:</p> <p>The record review for Resident #47 was completed on 8/22/13 at 1 P.M. Diagnoses included, but were not limited to, diabetes, Kwashiorkor disease (malnutrition of protein), depression, and vascular dementia.</p> <p>In an interview on 8/19/13 at 1:30 P.M., LPN #1 indicated the resident had an unstageable wound.</p> <p>The wound documentation, dated 8/15/13, indicated the sacrum area was a "UTD" (unable to determine) wound. The area measured 1.2</p>	F000314	<p>I. On 8/22/13 Resident #47 had a pressure ulcer assessed by LPN#7 and DCS in the presence of the surveyor, it was determined to be a Stage II pressure ulcer. The Pressure Ulcer Record was updated and correct staging noted. II. All residents with pressure ulcers had a treatment observation by the DCS or designee to ensure all staging was accurately assessed and documented on the the Pressure Ulcer Record. III. Licensed Nurses were educated on wound assessment, including pressure ulcer staging. The DCS or designee will observe all pressure ulcers weekly to ensure they are accurately staged. The DCS will initial the Pressure Ulcer Record entry if done accurately and recorded. If there is a discrepancy the DCS or designee will complete a new entry on the record with the correct assessment and stage. IV. Licensed Nurse responsible.</p>	09/22/2013	

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 08/23/2013	
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>centimeters in length by 1.4 centimeters in width by 0.2 centimeters in depth. The wound bed had granulation with a red center. The edges were firm with no redness. There was no drainage or odor. The stage of the wound was documented as "UTD." The document was signed by LPN #7.</p> <p>In an interview on 8/20/13 9:52 A.M., LPN #1 indicated the wound documentation for 8/15/13 that read "UTD" probably meant it was unstageable such as purple and necrotic. He indicated each nurse on the night shift does the wound care.</p> <p>In an interview on 8/22/13 at 1:15 P.M., the ADON (Assistant Director of Nursing) indicated when she had recently observed the wound it was a Stage II. After reviewing the wound documentation for 8/15/13, she indicated if the area had depth to it, she did not know why staff was documenting it as UTD or unable to determine.</p> <p>In an interview on 8/22/13 at 2:44 P.M., LPN #7 indicated she had reviewed the policy with the Director of Nursing prior preparing to do the dressing change.</p>		DCS/or designee will monitor. Findings will be reported monthly at th QAPI meeting, V. 9/22/13				

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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 8/22/13 at 2:50 P.M., an observation of the wound was done with the DON (Director of Nursing) and LPN #7 in attendance. The wound was observed to have pink granulation tissue. LPN #7 measured the wound with a sterile Q tip. She measured the width and length with the tip of the Q-tip, and a quarter of the tip was able to be inserted into the wound. The wound had firm edges and no odor or drainage was noted.</p> <p>After completing the wound measurements, LPN # 7 indicated the wound would be considered a Stage II wound.</p> <p>In an interview on 8/22/13 at 2:55 P.M., the Director of Nursing indicated she was not sure why LPN #7 would have documented the wound as UTD on 8/15/13, as it was clearly a Stage II wound.</p> <p>On 8/22/13 at 1:35 P.M., the ADON provided a skin care protocol policy. The policy indicated "...A Stage 2 is a partial thickness skin loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough...." There was no UTD staging in this policy information.</p> <p>3.1-40(a)(2)</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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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 08/23/2013	
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=E	<p>483.25(I) 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 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 a specific behavior was identified, adequately monitored, and/or quantitatively tracked to support the use of psychotropic medications. Further, the facility failed to ensure adverse side effects of a non-psychotropic medications were adequately monitored. This deficient practice affected 5 of 5 residents reviewed for Unnecessary Medication Use. (Residents #6, #32, #83, #86,</p>	F000329	I. Residents #86,83,32,6,& 88 were reviewed on 9/10/11 to ensure the specific behaviors were identified and adequate monitoring and tracking systems were in place and side effects of antipsychotics were being monitored. II All residents receiving antipsychotic were identified to ensure specific behaviors were identified and adequate monitoring tracking systems were in place and side effects were being monitored. III. Education was provided to all nursing and social service staff	09/22/2013			

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 08/23/2013	
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 #88)</p> <p>Findings include:</p> <p>1. The record for Resident #86 was reviewed on 8/21/13 at 9:15 A.M. An acute care hospital progress note, dated 4/29/13, indicated resident had become more confused over the week-end and was now actively hallucinating. Diagnoses at that time included, but were not limited to, rhabdomyolysis, acute kidney failure, metabolic encephalopathy, depression and anxiety. A hospital Social Service progress note, dated 5/1/13, indicated the resident's primary diagnosis was dementia with a subsequent resolution of her psychosis.</p> <p>Physician orders upon admission 5/1/13 included Clonazepam (Klonopin--an anti-convulsant also used as a mood stabilizer), Risperdal (an anti-psychotic), Wellbutrin (an antidepressant), and Risperdal PRN (as needed) for severe agitation.</p> <p>A consultant psychiatric evaluation report, dated 5/23/13, indicated the Risperdal was to be decreased to 0.5 mg. (milligrams) twice a day for 2 weeks, then decreased to 0.5 mg. every morning for 2 weeks, then</p>		<p>on antipsychotic side effect monitoring and behavior identification, monitoring and tracking. All residents receiving antipsychotic medications will be reviewed montly in Behavior/GDR meeting. The DCS or designee is to review the residents medical record prior to the nurse asking for a change in antipsychotic medications to ensure that underlying medical, physical, functional, pschococial, emotional psychiatric and environmental causes have been addressed, not withstanding emergent situations. IV. The ADCS or designee will review 6 residents on antipsychotics every month for 3 months, then quarterly, utilizing the Psychotropic Drug review Performance Improvement tool. The Psychotropic Drug Review Performance improvement tool will be submitted to monthly QAPI meeting for review. V. 9/22/13</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>discontinued.</p> <p>A nurse's progress note, dated 7/1/13 at 3:45 P.M., indicated "Contacted physician regarding resident complains of being 'jittery' since discontinuing Risperdal. Will await return call." A note on 7/2/13 at 9:00 A.M. indicated "New order [for] Risperdal 0.5 mg. po (by mouth) QD (every day) related to agitation...."</p> <p>A specific behavior to support the use of the Risperdal, with a quantitative tracking of the number of episodes, was not found for this resident.</p> <p>In an interview on 8/22/13 at 10:20 A.M., the Social Service Director indicated she was involved with the Behavior Management program. She indicated she would need to research reason the Risperdal had been prescribed, what the targeted behavior was, and where the tracking for the targeted behavior was documented.</p> <p>In an interview on 8/22/13 at 2:00 P.M., the Social Service Director indicated she could not locate any information or documentation related to behavior tracking.</p> <p>2. The record for Resident #83 was</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>reviewed on 8/22/13 at 10:45 A.M. An acute care hospital consultant psychiatrist report, dated 5/16/13, indicated discharge diagnoses at that time included, but were not limited to, dementia--probably vascular/mixed (vascular/Alzheimer's) with mood lability, anxiety and disturbance of behavior, psychosis due to illness, and recent delirium due to poorly controlled diabetes and urinary tract infection.</p> <p>The August, 2013 physician's order recap (recapitulation) sheet listed medications which included: 6/11/13--Seroquel (an antipsychotic medication) 50 mg. 1 po twice a day.</p> <p>A specific behavior to support the use of the Risperdal, with a quantitative tracking of the number of episodes, was not found for this resident.</p> <p>In an interview on 8/22/13 at 10:20 A.M., the Social Service Director indicated she was involved with the Behavior Management program. She indicated she would need to research what the targeted behaviors were, and where the tracking for the targeted behavior was documented.</p> <p>On 8/23/13 at 9:00 A.M., the Social Service Director provided a "Behavior</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>Detail Report" for Resident #83, for the time period of 5/1 through 8/22/13. The report indicated the resident had an episode of "wandering" seven times; "socially inappropriate/other" three times, and "verbal behavior" one time. The report did not identify a specific behavior that was to be monitored to support the use of the Risperdal.</p> <p>3. Resident #32's record was reviewed on 8/23/13 at 9 A.M. Diagnoses included, but were not limited to, dementia with behavior disturbances</p> <p>On 8/21/13, the dosage of the prescribed Risperdal (antipsychotic medication) was decreased from 0.5 milligrams by mouth daily to the current dosage of 0.25 mg. daily.</p> <p>The Social Service Director (SSD) provided a behavior chart on 8/23/13 at 1:30 P.M., which listed the types of behaviors the staff members were to monitor the resident for such as; wandering, wandering alterable, verbal abuse, verbal alterable, physical abuse, physical alterable, social inappropriate, social inappropriate alterable, resists care, and resists care alterable.</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 08/23/2013
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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 the interview on 8/22/13 at 2 P.M., the SSD indicated she was unable to locate any behavior monitoring or tracking methods specific to this residents's Risperdal.</p> <p>4. Resident #88's record was reviewed on 8/22/13 at 1:35 P.M. Diagnoses included, but were not limited to, frontotemporal dementia syndrome.</p> <p>Current medications included, but were not limited to, Risperdal 0.25 milligrams by mouth twice daily and Risperdal Consta 12.5 milligrams intramuscular every 14 days.</p> <p>The Social Service Director (SSD) provided a behavior chart on 8/23/13 at 1:30 P.M., which listed the types of behaviors the staff members were to monitor the resident for such as; wandering, wandering alterable, verbal abuse, verbal alterable, physical abuse, physical alterable, social inappropriate, social inappropriate alterable, resists care, and resists care alterable.</p> <p>During the interview on 8/22/13 at 2 P.M., the SSD indicated she was unable to locate any behavior monitoring or tracking methods</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 08/23/2013
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>specific to this residents's Risperdal.</p> <p>5. In an interview on 8/21/13 at 11:18 A.M., LPN #1 indicated the CNAs use the Care Tracker computer system to document any behaviors they have observed. The nursing staff document behaviors in the nursing progress notes. There is no separate behavior monitoring/tracking form in the MAR (Medication Administration Record) or other type of log or tracking form used by licensed nurses to identify the behavior that prompted the use of a psychotropic medication, or to quantitatively track the number of episodes of that behavior.</p> <p>In an interview on 8/23/13 at 9:45 A.M., the Social Service Director indicated the Care Tracker system for documentation of health information had a prompt for "Mood" symptoms, which the CNAs must respond to when entering information into the system. The categories were the same for all residents: negative statements, repetitive questions, repetitive verbal, persistent anger, self deprecation, unrealistic fears, terrible things to happen, repetitive health (complaints), repetitive anxious, unpleasant mood, insomnia, sad/pained/worried, crying, repetitive physical, withdrawn from 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>and social interaction.</p> <p>The Social Service Director indicated there was also a prompt for "Behaviors." The categories again were the same for all residents: wandering, wandering alterable, verbal abuse, verbal (abuse) alterable, physical abuse, physical (abuse) alterable, socially inappropriate, socially inappropriate alterable, resists care, and resists (care) alterable.</p> <p>The Social Service Director indicated a report, totaling the number of times a mood or behavior in one of these categories was observed and entered into the Care Tracker system, was generated for the weekly and monthly behavior meetings for administrative staff to review. Licensed nurses were supposed to chart behaviors in the nurse's progress notes. The Social Service Director indicated she physically read through the progress notes for nursing documentation of behaviors, but she did not keep track of the type, or number of episodes documented. In addition, the Behavior Committee reviewed only the previous one month of the entries entered into the Care Tracker system. She indicated she did not document in a summary-type of format a</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>compellation of the episodes or the discussion/decisions made by the committee.</p> <p>6. Resident #6's record was reviewed on 8/22/2013 at 10 A.M. Diagnoses included, but were not limited to, cerebral palsy, feeding tube dependent since 1980, general muscle weakness, multiple contractures, tracheostomy, and history of paralytic ileus.</p> <p>The physician's order upon admission in May 2013, and the physician order recap (recapitulation) sheets through 7/31/2013 indicated the resident had an order and was being administered the tricyclic antidepressant Amitriptyline 25 mg. (milligrams) via feeding tube.</p> <p>Resident # 6's record indicated he had a history of paralytic ileus (paralysis of the bowel that can cause intestinal blockage in the absence of an actual physical obstruction).</p> <p>According to Nursing Spectrum Drug Handbook, 2010 edition, Amitriptyline has the following side effects or adverse reactions: "GI (gastro-intestinal)--nausea, vomiting, constipation, dry mouth, epigastric</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>pain, anorexia, paralytic ileus"</p> <p>During an interview on 8/23/2013 at 3:15 P.M., the DON (Director of Nursing) and the ADON (Assistant Director of Nursing) indicated the resident had a recent episode of paralytic ileus, and upon medication review at their weekly meeting found that this could be an adverse reaction with Amitriptyline. They subsequently contacted the physician.</p> <p>3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(a)(5)</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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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review the facility failed to follow appropriate sanitation practices while prepping and serving food. The facility failed to maintain foods at a safe temperature, failed to develop an appropriate cleaning schedule and failed to ensure the dietary staff used correct food handling procedures. The deficient practice had a potential to affect 63 of 65 residents served food from the 1 of 1 kitchens.</p> <p>Findings include:</p> <p>A tour of the kitchen was conducted on 8/18/13 at 4:45 P.M., with Cook #10.</p> <p>A. A 44 ounce drink in a cup with a lid and a straw, and an open 12 ounce can of Mountain Dew were observed sitting on the counter where the dinner meal had been prepped.</p> <p>During an interview on 8/20/13 at 2 P.M., the Regional Director of</p>	F000371	<p>I. Immediately personal items were removed from the kitchen. The oven was cleaned the evening it was observed. Staff were educated on 8/19/13 regarding usage of sanitizer buckets. The meat was disposed of immediately. The scoops were removed from the bins. Handwashing was addressed with all employees. II. All residents have the potential to be affected by this deficient practice. An area in the kitchen office has been designated for all drinks and personal items. The ovens have been added to the cleaning schedule. The cleaning schedule was reviewed to ensure all equipment has been scheduled. A cooling log has been implemented to insure foods are put into the cooler at 135 degrees. III. All dietary staff were inserviced on 8/19&20/13 1. Cross contamination when personal items are in the kitchen 2. Cleaning schedules being followed. 3. Usage of sanitizer buckets, each and every shift. 4. Use of a cooling log to ensure items placed in cooler at 135 degrees. 5. The removal of</p>	09/22/2013			

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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>Nutrition Services indicated there should not be any personal items in the kitchen.</p> <p>B. The convection and the double ovens were observed to have food burnt on the sides and the bottoms of the ovens. The back of the ranges were visibly dirty with a brown looking substance.</p> <p>During an interview, on 8/18/13 at 6 P.M., Cook #10 indicated he did not know when the ovens were to be cleaned.</p> <p>During an interview on 8/19/13 at 8:40 A.M., the Dietary Manager indicated the ovens were cleaned when they needed to be cleaned, and were not on any routine cleaning schedule. She indicated the range was cleaned weekly and wiped down daily. She indicated the ovens were sprayed and cleaned last night.</p> <p>C. The Quat disinfecting solution and water buckets were observed to be empty and had dried white cloths in them with a brown substance on the cloths.</p> <p>During an interview on 8/18/13 at 5:02 P.M., Cook #10 indicated he had not made up any disinfecting solution</p>		<p>scoops or other utensils from bins. 6. Proper handwashing and glove usage. Dietary Manger will monitor daily for 4 weeks, then randomly for 4 weeks and monthly thereafter. RD to monitor monthly during visist. Employees will receive disciplinary action if policies are not followed. IV. Dietary employees responsible, Dietary Manager and RD to collect data and review with QAQI monthly. V. September 22, 2013</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>this shift.</p> <p>During an interview on 8/19/13 at 8:40 A.M., the Dietary Manager, she indicated the Quat disinfecting solution was to be changed before every meal.</p> <p>D. On 8/18/13 at 5:10 P.M., ground meat was observed in a steam-and-hold oven. The oven doors were left open, and the oven was not turned on. The bottom of the pan was lukewarm.</p> <p>During an interview at that time, Cook #10 indicated the substance in the pan was ground beef and it had been in the steam-and-hold oven for ten minutes. He indicated he was going to use it tomorrow for dinner.</p> <p>During an interview on 8/18/13 at 6 P.M., Cook #10 indicated he had fixed the ground beef at 2 P.M. He obtained the temperature of the meat at that time and indicated the temperature was 90 Fahrenheit (F). He indicated his normal procedure for storing meat after cooking it was to drain off the grease, then let the meat "reach temperature" (cool down), which he indicated was 75 F, then place it in the refrigerator. He indicated since the ground beef had</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>been sitting longer than he had intended for it to, he would throw it away.</p> <p>During an interview on 8/19/13 at 8:40 A.M., the Dietary Manager indicated food was cooked to temperature, then when it reached 145 F or sooner, the food was placed in the refrigerator.</p> <p>E. On 8/18/13 at 5:15 P.M., a container of chocolate cocoa was observed to have what appeared to be a white measuring cup in it.</p> <p>During an interview on 8/18/13 at 6 P.M., Cook #10 indicated there was a soufflé cup in the chocolate cocoa container that was not suppose to be there. He removed the cup.</p> <p>F. On 8/18/13 from 5:10 P.M. to 6:00 P.M., Cook #10 was observed picking up the phone three times (then he served dinner without having washed his hands). While serving the dinner meal he used the phone and touched the edge of the plate with his thumb. He continued to serve food onto the plate. He did not wash his hands after he used the phone.</p> <p>On 8/20/13 at 2 P.M., the Regional Director of Nutrition Services</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>indicated that if the staff members wore gloves and used the phone they should deglove, should wash their hands and should donn new gloves again before they served food. She indicated if staff members did not wear gloves and used the phone, they would wash their hands before they served food again.</p> <p>A review of the policy titled "Sanitation Inspections, Nutrition, and Food Service" dated 1/1/07, was provided by the Regional Director of Nutrition Services on 8/21/13 at 4:47 P.M., and deemed as current. The policy indicated cooked foods needed to be refrigerated as soon as possible after cooking and never held at room temperature. It indicated all non-food products were to be stored separately from food products, cleaning products and chemicals. It indicated that all kitchen equipment needed to be thoroughly cleaned and sanitized after each use.</p> <p>A review of the policy titled "Food Temperatures" dated 1/1/07 was provided by the Regional Director of Nutrition Services on 8/21/13 at 4:47 P.M., and deemed as current. The policy indicated food temperatures were monitored at all critical points to ensure safety and acceptability. It</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>indicated hot food items must be cooled to 70 F. within two hours and be at 41 F or less within the following four hours. It indicated the evening cook should check the temperature of stored items prior to clocking out to ensure the items are at 70 F. or less.</p> <p>A review of an undated inservice titled "Wearing Gloves" was provided by the Regional Director of Nutrition Services on 8/21/13 at 4:47 P.M., and deemed as current. The inservice material indicated that gloves must be changed and hands must be washed any time the tray service is interrupted when the staff member leaves the tray line for another task.</p> <p>3.1-21(i)(3)</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 08/23/2013
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	
F000428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on interview and record review, the facility failed to ensure the consultant pharmacist was reporting irregularities with a psychotropic medication, for 1 of 4 residents reviewed for Nutrition. (Resident #6)</p> <p>Findings include:</p> <p>Resident #6's record was reviewed on 8/22/2013 at 10 A.M. Diagnoses included, but were not limited to, cerebral palsy, feeding tube dependent since 1980, general muscle weakness, multiple contractures, tracheostomy, history of paralytic ileus.</p> <p>The physician's order upon admission in May 2013, and the physician's order recap (recapulation) sheets through 7/31/2013 indicated the resident had an order and was being administered the tricyclic antidepressant Amitriptyline 25 mg. (milligrams) via feeding tube. The</p>	F000428	<p>I. The IDT team noted during the weekly care management meeting that Resident #6 was receiving Amitriptyline and had a recent episode of paralytic ileus, which is listed as an adverse reaction. The physician was notified and a new order was obtained on 8/21/13 to wean amitriptyline x 14 days then discontinue. The pharmacist recommendations since 5/14/13 were reviewed and it was noted on 5/14/13 a re evaluation of Amitriptyline use d/t side effects of urinary retention and tachycardia. Also recommended on 7/11/13 re evaluation of Amitriptyline use due to no diagnosis or documented clinical rationale for its use. II. The IDT team reviewed all residents receiving psychotropic medications for irregularities. Any noted irregularities were reported to the physician and new orders noted as applicable. A meeting was held with the consultant pharmacist on 9/11/13 in regards to Resident #6 and all residents on psychotropic medications. III.</p>	09/22/2013	

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 08/23/2013
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>resident was ordered to receive Amitriptyline 25 mg. every 8 hours upon admission, which was decreased to two times per day on 7/20/13.</p> <p>Resident # 6's record indicated he had a history of paralytic ileus (paralysis of the bowel that could cause intestinal blockage in the absence of an actual physical obstruction).</p> <p>According to Nursing Spectrum Drug Handbook, 2010 edition: Amitriptyline can have the following side effects or adverse reactions: "GI (gastro-intestinal)--nausea, vomiting, constipation, dry mouth, epigastric pain, anorexia, and paralytic ileus"</p> <p>During an interview on 8/23/2013 at 3 P.M., the DON (Director of Nursing) and the ADON (Assistant Director of Nursing) indicated the resident had a recent episode of paralytic ileus. Upon review of all of the resident's medications at their weekly meeting, they found that this could be an adverse reaction with the Amitriptyline. They subsequently contacted the physician.</p> <p>The consultant pharmacist's drug regimen review had failed to report</p>		<p>The interdisciplinary team will continue to meet weekly and review psychotropic medications for irregularities. Any noted irregularities will be reported not only to the physician, but also the pharmacist for further review. This will be noted in the social service progress notes. IV. The SSD will submit any social service progress notes pertaining to pharmacist notification of psychotropic medication irregularities in the month QAPI meeting for review. V. 09/22/13</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 08/23/2013
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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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 08/23/2013	
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	<p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</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, record review and interview, the facility failed to</p>	F000441	I. CNA #8 was educated on 8/22/13 by the DCS on sanitary	09/22/2013			

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 08/23/2013	
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>ensure the facility utilized sanitary practices while completing perineal care to prevent contamination of a wound, and failed to ensure gloves were changed properly to reduce the potential for cross-contamination of the wound during wound care, for 2 of 3 observations completed for Infection Control. (Resident #47 and #53)</p> <p>Findings include:</p> <p>1. On 8/22/13 at 2:45 P.M., CNA #8 was observed while providing incontinence and perineal care to Resident #47.</p> <p>Prior to the wound care and dressing change, LPN #7 indicated the resident had some stool in her adult brief, and requested the CNA #8 to provide incontinence care and clean the area.</p> <p>CNA #8 brought in a washcloth wet with soapy water to wipe the resident's perineal area. CNA #8 washed from the front (labia area) to the back, and from the rectum to the coccyx wound with washcloth. The CNA got some of the stool on the washcloth, which she wiped directly into the uncovered wound and wound bed. She got another wash cloth, wet</p>		<p>practice while completing perineal care to prevent contamination of wounds. LPN#1 was educated and given an employee corrective action in regards to changing gloves during wound care to reduce the potential for cross contamination. II. The DCS or designee completed random perineal care observations on all residents with pressure ulcers to ensure sanitary practice was used to prevent contamination of wound. The DCS or designee completed random wound care on all residents with pressure ulcers to ensure gloves were changed properly to reduce potential for cross contamination of wound. III. CNAs were educated and had to complete skills review on using sanitary practice when completing perineal care to prevent contamination of wound. Education and skills review will be repeated quarterly x 4. All newly hired CNAs will be educated and a skills review completed within 5 days of hire. Licensed nurses were educated on wound care, including changing of gloves to reduce the potential for cross contamination. The DCS or designee will observe wound care once every week to ensure that gloves were changed properly to reduce the potential for cross contamination of the wound. IV. Nursing staff responsible DCS or designee to monitor. Reviews of CNA perineal skills and 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 08/23/2013
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	<p>with plain water, and wiped all the way from front to back and directly into the wound bed area. LPN #7 watched as she did this.</p> <p>On 8/22/13 at 2:50 P.M., the Director of Nursing indicated CNA #8 should not have used the wash cloth to wipe from the rectum into the wound.</p> <p>2. The record for Resident #53 was reviewed on 8/21/13 at 12:50 P.M.</p> <p>Resident's orders included, but were not limited to:</p> <p>4/10/13-left fifth toe treatment to be cleansed with wound cleanser, apply Santyl to slough tissue, and cover with a dressing daily. The wound was to be measured daily</p> <p>6/20/13-left buttocks/sacrum treatment to be changed with a wet to dry dressing daily. The wound was to be measured with each dressing change.</p> <p>On 8/21/13 at 1:40 P.M., LPN # 1 was observed changing dressings to the left fifth toe and the coccyx. He washed his hands and donned clean disposable gloves. He removed the soiled dressing from the left fifth toe area, cleansed the wound, and</p>		wound care observations will be submitted at the monthly QAPI meeting.		

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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>applied a clean dressing without having changed his disposable gloves or having washed his hands. Following this he removed his soiled gloves and washed his hands and applied clean disposable gloves. He removed the soiled dressing from the coccyx area, cleansed the wound, and applied a clean dressing without having changed his disposable gloves or having washed his hands. He removed his soiled gloves and washed his hands following the coccyx dressing change.</p> <p>Resident # 53 had been treated for Methicillin Resistant Staphylococcus Staph Aureus (MRSA) in her fifth left toe wound on 7/11/13 and 8/6/13 for 10 days each with Keflex and Doxy antibiotics.</p> <p>During an interview on 8/21/13 at 1:53 P.M., LPN #1, indicated he should have washed his hands after he changed his gloves and once he had cleansed and dressed the wound.</p> <p>Review of a policy titled "Wound Care" dated 1/1/07 was provided on 8/22/13 at 8:40 A.M., by the Administrator. The policy indicated the soiled dressing was removed and disposed of according to their</p>			

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	<p>Exposure Control Policy. Gloves were removed and hands were washed, then new gloves were applied. The wound was cleansed and dried. The dressing was applied, then the gloves was removed and hands was washed.</p> <p>Review of a policy titled "Disposal Non-Sterile Gloves" dated 1/1/07 was provided on 8/22/13 at 8:40 A.M., by the Administrator. The policy indicated hands would be washed and gloves would be changed between different body site procedures performed subsequently on the same resident. The policy indicated when a procedure required gloves to be worn to remove a dressing, hands were washed and clean gloves were worn. When the dressing had been removed, then gloves needed to be removed. If the hand surfaces were not contaminated, the gloves used for performing the procedure could immediately be donned. Hands were washed if contamination occurred when the second pair of gloves were removed.</p> <p>3.1-18(l)</p>						

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F000465 SS=C	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview and record review, the facility failed to ensure 2 of 2 air handlers and 2 of 2 wall air conditioner unit filters and grills in the main dining room were kept free from debris. This deficit practice had the potential to impact 30 of 30 residents eating in the main dining room.</p> <p>Findings include:</p> <p>On 8/21/13 at 10:07 A.M., the grills on the fronts of the air conditioner units, the air filters inside the grills, and the grill coverings on the air handlers on both sides of the main dining room were observed to have had a gray fuzzy buildup on them.</p> <p>During the interview on 8/21/13 at 10:25 A.M., the Maintenance Director indicated the air handlers on both sides of the dining room were not in use unless there was an emergency and heat was needed. He indicated the air conditioner unit at the north end of the main dining room was not functional at this time and the one at the south end of the main dining room</p>	F000465	<p>I. Both air handlers and air conditioner units in main dining room were cleaned immediately.</p> <p>II. All residents have a potential to be affected. All air handlers and air conditioner units were checked for debris and cleaned as indicated on 8/26/13</p> <p>III. Air handler units are on an annual cleaning schedule to be completed by the Maintenance Director as indicated. Air conditioners were placed on a quarterly cleaning schedule, for the Maintenance Director. The Housekeeping Supervisor will observe air conditioning units and air handlers during monthly unit inspections. If cleaning is indicated a work order will be given to the Maintenance Director for completion.</p> <p>IV The Maintenance Director is responsible. The Housekeeping Supervisor will monitor during routine Unit Inspections. The log will be submitted to the QAPI committee monthly.</p> <p>V. September 22, 2013</p>	09/22/2013			

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	<p>only blew air out of the bottom of the unit. This area had a thick amount of gray debris on it. When the Maintenance Director touched this area with his right index finger, an imprint of his finger was left on the grill part.</p> <p>The Maintenance Director removed the air filter from the air conditioner unit at the south end of the main dining room. When he rubbed the air filter with his index finger he left an imprint of his finger on the filter and had balls of thick gray debris on the tip of his right index finger.</p> <p>He indicated the air handlers were cleaned once a year before the heating season begun and the air conditioner units were cleaned every 3 months.</p> <p>An undated policy titled "HVAC (PTAC): Clean air filters" was provided by the Maintenance Director on 8/21/13 at 10:38 A.M., and deemed as current. The policy indicated the air filters were to be inspected for cleanliness and if they were dirty, they were to be washed or replaced depending on the type of the filters. The grill covers were to be cleaned and at a minimum, the air filters on the air conditioner units were</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>to be replaced or thoroughly cleaned depending on the type of filters every three months.</p> <p>A work history with a due date timeframe that had indicated the last 12 months was provided by the Maintenance Director on 8/21/13 at 10:38 A.M., and deemed as current. The work history indicated the air conditioner unit air filters had been cleaned on 8/31/12 and 5/31/13.</p> <p>3.1-19(f)</p>			

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F000514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, record review and interview, the facility failed to provide complete, organized, and accurate documentation for 2 residents in a sample of 27. (Residents #53 and #6)</p> <p>Findings include:</p> <p>1. Resident #6's record was reviewed on 8/22/2013 at 10 A.M. Diagnoses included, but were not limited to, cerebral palsy, general muscle weakness, multiple contractures, tracheostomy.</p> <p>Admission assessment and data collection documentation was not initially accessible for review. The staff person responsible for medical records was able to locate the</p>	F000514	<p>I. The entire medical record for Resident #6 was organized by the ADSC on 8/23/13 including the Admission Date Collection Form and all documentation related to skin assessments, measurements and treatments. The medical record for Resident #53 was organized by the Medical Records Designee including an updated diagnosis list and all documentation related to skin assessments, measurements and treatments. The DCS inserviced Licensed Nurses on 8/23/13 on correct skin forms to document wounds. II. All residents have the potential to be affected. All active medical records were reviewed by the Medical Records Designee to ensure they were complete, accurate, readily accessible and systematically organized. All active medical records were reviewed to ensure admission</p>	09/22/2013			

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	<p>information after 25 minutes of looking through thinned chart information.</p> <p>The facility nursing admission documentation indicated Resident #6 had a terminal illness. However, a terminal illness was not identified in the facility-generated MDS (Minimum Data Set) assessment to confirm that this was correct.</p> <p>Documentation related to skin and pressure ulcer assessments, measurements, and treatments, with clear information related to the dates of occurrence and the progression of the the skin treatments and care, was not found in the current chart. The documentation in his current chart did not clearly identify what was being measured and the progression of the treatment provided. The chart had been thinned significantly with current information starting on 7/28/13.</p> <p>During an interview on 8/23/2013 at 8:30 A.M., the DON (Director of Nursing) and the ADON (Assistant Director of Nursing) indicated they would need some time to find the information to give a time line regarding assessments, skin care and course of treatment. At 3 P.M., on 8/23/2013, after 6 1/2 hrs., the DON</p>		<p>Data Collection Forms were in the active chart. All diagnosis lists were reviewed and updated for accuracy. New diagnosis lists were printed for all active residents and placed in the chart. III. The Medical Record Designee, Nursing Management and Licensed Nurses were educated on correct chart order and thinning schedule. Licensed Nurses were educated on documentation of wounds. Additional tabs were added to charts as indicating seperating skin related documentation and dialysis documentation to improve organization. Active resident charts will be thinned monthly according to their thinning schedule by the Medical Record Designee. IV. The Medical Record Designee and Nursing Staff responsible. The Unit Managers will monitor by auditing two charts per side per month to ensure they are complete, accurate, readily accessible and systematically organized. The medical record designee will complete a chart audit within 30 days on all new admissions. Any areas of deficiency requiring attention will be listed on the Chart Audit Results form and given to the appropriate personnel. Chart Audit Results will be submitted in monthly QAPI. V. Setember 22, 2013</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 ADON were finally able to organize the information needed to view the information regarding Resident #6's skin care and time line with the treatment given.</p> <p>2. During an observation of a dressing change to the left fifth toe of Resident # 53 on 8/21/13 at 1:40 P.M., LPN #1 indicated the wound was a stage 3 pressure ulcer, but was staged as a stage 4 at one time.</p> <p>Record review of Resident #53's record on 8/21/13 at 12:50 P.M.</p> <p>The resident had a diagnosis written on 5/16/13 for bullosis diabeticorum (a spontaneous, noninflammatory, blistering condition of unknown cause occurring in people with diabetes mellitus).</p> <p>The skin sheet indicated on 8/11/13 the left fifth toe wound was identified as unable to determine the stage.</p> <p>During the interview on 8/22/13 at 1 P.M., the Assistant Director of Nursing (ADON), indicated the resident was diagnosed with bullosis diabeticorum on 5/16/13, and the area on her outer aspect of her left foot was not a pressure ulcer.</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 the interview on 8/23/13 at 3:10 P.M., the Director of Nursing, indicated the nurses in the facility were verbally educated by the ADON after 5/16/13 regarding the resident's left fifth toe wound was not a pressure ulcer.</p> <p>3.1-50(a)(2) 3.1-50(a)(4)</p>			

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F000520 SS=F	<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 observation, interview and record review, the facility failed to identify repeat non-compliance issues related to Care Plan entries and interventions, kitchen sanitation and food preparation protocols, and infection control and prevention, through the Quality Assurance protocol. This deficient practice had the potential to impact 65 of 65 residents residing in the facility.</p>	F000520	I. A meeting will be held on 9/18/13 to evaluate the current process of the QAQI and its lack of effectiveness for identification repeat non-compliance issues related to Care Plan entries, kitchen sanitation, food preparation and infection control. All issues that could be corrected were corrected immediately. II. Every resident has a potential to be affected by this practice. See POCfor F-279, 282, 371 and 441 for identification of residents who are at risk and how corrective	09/22/2013	

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 08/23/2013	
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	<p>Findings include:</p> <p>On 8/19/13, the Executive Director provided the "Performance Improvement Committee (Quality Assurance)" policy and procedure, which had an effective date of 1/1/07 and a revision date of 9/1/11.</p> <p>The "Policy" section indicated "The Performance Improvement Committee will meet monthly to review, recommend and act upon activities of the facility, performance action teams and/or departmental activities. The committee shall direct all activities including approving proposed monitoring, evaluating, and review of services. The committee will assure activities have written indicators and standards/thresholds for evaluation, that appropriate actions are implemented, and that such correction has been evaluated by subsequent monitoring."</p> <p>The "Procedure" section indicated the committee "may consist of" various department manager or supervisors, such as Medical Director, Executive Director, Director of Clinical Services, Social Worker, Activities Director, etc. The section also indicated the committee "will assign interdisciplinary performance action</p>		<p>action will be taken. III. A new Executive Director will begin on 9/16/13 who is an RN with extensive experience. She will lead and assess the QAPI process. Specific corrections for each tag can be found in POC F-279,282,371 and 441. IV. Each discipline will be responsible for direction given by the QAPI committee and the Executive Director will monitor for effectiveness. V. September 22, 2013</p>				

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	<p>teams activities and monitor the team's progress. A Performance Action Team will be developed to collect and evaluate data and to plan and implement needed action under the direction of the Performance Improvement Committee. Action teams will be comprised of representatives of the primary departments involved with the aspect of care or service being evaluated, other affected staff, residents/families and other appropriate community/customer representatives...."</p> <p>In an interview on 8/22/13 at 12:15 P.M., the Executive Director indicated the Dietary, Housekeeping/Laundry, and Therapy departments were "out-sourced," with the services provided through contracts negotiated through the Corporate office. She indicated that the Dietary management was changed by Corporate the first of June, 2013, resulting in all new staff and a Dietary Manager who was also a Registered Dietitian.</p> <p>She indicated the facility Quality Assurance Committee reviews data collected on multiple issues, and performs a special focus review for some care issues as well as a "mock"</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>survey. The facility Quality Assurance Committee meets monthly, and does review the CASPER 3 report for repeat survey citations, even though it was not referred to in the policy/procedure.</p> <p>During the Recertification survey process from 8/18/13 to 8/23/13, resident observations, interviews, and record review indicated that 5 of 27 residents reviewed for Care Plan development and interventions lacked either an updated Care Plan entry, or lacked specific interventions to be provided by the facility for an identified problem. Residents #83 and #86 lacked specific, appropriate interventions for behaviors that required psychotropic medications; Resident #32 lacked an entry or interventions for skin issues and bruising; Resident #42 lacked a coordinated facility/Hospice Care Plan; and Resident #87 lacked an up-dated entry addressing non-compliance with a personal alarm.</p> <p>Observations of the facility kitchen and dining rooms from 8/18/13 to 8/23/13 indicated there was improper cooling of cooked meat; kitchen ovens had burnt spillage, with no routine cleaning schedule; improper</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 08/23/2013
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>handling of plates during food service; incorrect handwashing and glove use techniques; lack of sanitation solution for wiping counters, and dirty air vent grills.</p> <p>Observations of wound and incontinence care from 8/18/13 to 8/23/13 indicated there was lack of handwashing and incorrect glove use during wound care for Resident #53; and poor incontinence care with contamination of a wound for Resident #47.</p> <p>In an interview on 8/23/13 at 2:50 P.M., the Executive Director indicated the quantity and scope of QA (Quality Assurance) information and data was mandated by the Corporate office. The Care Plan development process was going to be modified to give more time to develop resident-specific care plans and interventions. Kitchen management was out-sourced in June. For infections and infection control issues, five CNAs a month were observed doing peri-care and hand-washing.</p> <p>3.1-52(b)(2)</p>				