

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155363	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PROFESSIONAL CARE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 404 W WILLOW RD DALE, IN 47523
---	--

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

F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: May 22, 23, 24, 25, 29, and 30, 2012</p> <p>Facility number: 000254 Provider number:155363 AIM number:100266270</p> <p>Survey team: Terri Walters RN TC Martha Saull RN Dorothy Watts RN Carole McDaniel RN (5/22, 5/23, 5/29, 5/30, 2012)</p> <p>Census bed type: SNF: 2 SNF/NF: 40 Total: 42</p> <p>Census Payor type: Medicare: 3 Medicaid: 35 Other: 4 Total: 42</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 6/06/12 by Suzanne</p>	F0000	<p>Preparation and/or Execution of this Plan of Correction in general, or any corrective action set forth herein, in particular, does not constitute an admission or agreement by Professional Care Rehabilitation of the facts alleged or the conclusions set forth in the Statement of Deficiencies. The Plan of Correction and specific corrective actions are prepared and/or executed solely because of provisions of Federal and/or State laws.</p> <p>Professional Care Rehabilitation desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on June 29, 2012.</p>	
-------	--	-------	---	--

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155363	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PROFESSIONAL CARE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 404 W WILLOW RD DALE, IN 47523
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	Williams, RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155363	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PROFESSIONAL CARE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 404 W WILLOW RD DALE, IN 47523
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to ensure the physician was notified of a resident's significant weight loss for 1 of 4 residents reviewed who met the</p>	F0157	Facility notified the FNP/MD of Resident #55 regarding significant weight loss. A Medical Record Review of in house residents to be conducted to ensure any occurrence of	06/29/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155363	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/30/2012
NAME OF PROVIDER OR SUPPLIER PROFESSIONAL CARE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 404 W WILLOW RD DALE, IN 47523		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>criteria for nutrition. Resident #55</p> <p>Findings include:</p> <p>The clinical record of Resident #55 was reviewed on 5/25/12 at 10 A.M. The resident was admitted to the facility on 3/23/12. Diagnoses included, but were not limited to, the following: hypertension, diabetes mellitus and recent hip fracture. The "Weight Detail Report" included the following weights for 2012: 3/23 = 255.6 lbs.; 4/4 = 231.2 lbs.; 4/4 = 231.2 lbs.; 4/30 = 222.8 lbs.; 5/6 = 222.8 lbs.; 5/9 = 220.4 lbs.</p> <p>On 5/25/12 at 2:12 P.M., the DON (Director of Nursing) was interviewed. She indicated the above weights were accurate including, but not limited to, the following: the 24.4 lb weight loss from 3/23/12 to 4/4/12. She indicated after admission the resident was to be weighed weekly for 4 weeks, then monthly. The DON indicated the resident was transferred back to the hospital on 4/15/12 with a diagnosis of acute renal failure. She indicated the resident returned to the facility on 4/24/12.</p> <p>On 5/29/12 at 9 A.M., the plan of care for Nutrition at Risk was reviewed.</p>		<p>significant weight loss the Resident's physician has been notified. Nurses will be re-educated on the policy and procedure for notification of weight loss to the MD/FNP and the procedure for documenting the notification of weight loss. IDT to review any resident with significant weight loss and ensure MD has been notified weekly x4 then monthly x 6 thereafter.</p> <p>Results of the above audits will be forwarded to the QPI committee for review and further recommendations as deemed appropriate until resolved. Reponsible persons are HFA and IDT</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155363		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/30/2012	
NAME OF PROVIDER OR SUPPLIER PROFESSIONAL CARE REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 404 W WILLOW RD DALE, IN 47523			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>This had an original date of 3/24/12. Interventions included but were not limited to the following: monitor weights x 4 weeks.</p> <p>On 5/29/12 at 9:15 A.M., the physician progress note dated 3/27/12 was reviewed. This note included, but was not limited to, the following: "nausea, this might be related to some of his pain medications, as this is a new issue for him..."</p> <p>On 5/30/12 at 8:00 A.M., the DON was interviewed. She provided documentation from the "Clinical Meeting for Follow Up Tool" notes from 5/11/12. The following was noted for "Reason for Review" : "4.67% in 30 days." Under the "Note" section, it was documented to "Notify POA, Document." At this time, the DON also provided a copy of the physician progress note dated 3/27/12. This note indicated the resident was experiencing nausea.</p> <p>On 5/30/12 at 9:30 A.M. the DON was interviewed. She indicated the resident was not weighed from his admission on 3/23 until 4/4/12. She indicated the reason for this was on admission the resident had not had an order written for weekly weights x</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155363	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PROFESSIONAL CARE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 404 W WILLOW RD DALE, IN 47523
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>4 weeks. The DON indicated the physician should have been notified of the 24.4 lb. weight loss from 3/23/12 until the 4/4/12 weight but documentation was lacking of the physician being notified. She indicated she feels sure the Nurse Practitioner was notified but the DON doesn't have documentation of this.</p> <p>3.1-5(a)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155363	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/30/2012
NAME OF PROVIDER OR SUPPLIER PROFESSIONAL CARE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 404 W WILLOW RD DALE, IN 47523		
(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	
F0253 SS=E	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>Based on observation, interview, and record review, the facility failed to ensure clean and safe bathrooms in regard to flooring, sinks, and commodes for its residents in 19 of the 40 resident bathrooms observed. This affected 35 residents that used these 19 bathrooms.</p> <p>Findings include:</p> <p>On 5/22/2012 at 1:00 P.M., during resident observations, bathroom floors and caulking around the commode were soiled and stained. Dirt and debris were observed along the edges of the wall and in the corners. The bathrooms were located in the following rooms: 1, 2, 4, 6, 7, 8, 9, 12, 14, 16, 18, 19, 23, 25, 27, 29, 31, 32, 35.</p> <p>On 5/28/2012 at 1:00 P.M., and on 5/29/2012 at 8:30 A.M., in room 31 the bathroom commode had a dried substance that appeared to be feces, located from the rim of the commode to the base of the commode and onto the floor. The bathroom had a strong odor of urine both days of</p>	F0253	<p>Identified bathrooms including flooring, thresholds, countertops, commodes and sinks deep cleaned as of 6-14-12. All toilet paper holders have been tightened or replaced 6-12-12. Resident bathrooms floors have been replaced on a stripping and waxing schedule. Re-caulking of resident toilets have been placed on a schedule. Room 25 commode, flooring and caulking to be replaced by 6-22-12. Sink drains in rooms 19, 23 and 31 to be replaced by 6-22-12. All staff were re-educated to fill out a work order when rooms are found to have strong odors, heavily soiled flooring, caulking, commodes, countertops, or sinks. All Housekeeping staff have been Re-educated regarding the 5-7 step deep cleaning process and wet/dry mopping floors. Daily rounds x 4 weeks then weekly x 6 months thereafter to be conducted by department heads to ensure bathrooms are clean and safe in regards to flooring, caulking, countertops, sinks and commodes. These results will be reviewed by the Administrator and Housekeeping manager. Results of the above audits will be forwarded to the QPI committee</p>	06/29/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155363		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/30/2012	
NAME OF PROVIDER OR SUPPLIER PROFESSIONAL CARE REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 404 W WILLOW RD DALE, IN 47523			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>observation.</p> <p>On 5/22/2012 at 2:12 P.M., 5/23/2012 at 10:30 A.M., 5/29/2012 at 11:05 A.M., and 5/30/2012 at 8:01 A.M., the bathroom in room 25 had areas of missing caulking around the base of the commode, several of the linoleum tile squares were peeling away from the commode base, and black debris was collected in the gaps. The commode had dried beige colored streaks from the top of the rim to the floor. The room had a strong pervasive urine odor each day. The door threshold located between the bathroom and the resident's room had collected dirt and debris.</p> <p>On 5/22/2012 at 1:00 P.M., it was observed in rooms 19, 23, and 31 the bathroom tissue dispensers were loose and falling away from the wall. The white sinks were stained brown around the drains and the sinks' formica counter tops were stained with brown rust colored rings.</p> <p>The facility's new employee training schedule was reviewed on 5/29/2012 at 2:30 P.M. This form indicated new housekeeping employees are trained and evaluated for job skill performance related to, but not limited to, 5 and 7 step cleaning procedures</p>		for review and further recommendations as deemed appropriate until resolved. Responsible Persons are HFA and IDT				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155363		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/30/2012	
NAME OF PROVIDER OR SUPPLIER PROFESSIONAL CARE REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 404 W WILLOW RD DALE, IN 47523			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>for resident rooms as well as wet mopping and dry mopping floors.</p> <p>On 5/29/2012 at 2:02 P.M., during a tour of bathrooms with the Maintenance Supervisor while in bathroom 31, he indicated the tissue dispenser was not anchored to the wall securely and should have been reported to maintenance for repair. He said it is both Maintenance and Housekeeping responsibility to report repairs when discovered. Also, at this time, he indicated the sinks' end counter tops were just old and stained.</p> <p>During an interview with Housekeeper #12 on the East hall on 5/29/2012 at 11:15 A.M., she said housekeeping staff deep clean 2 residents' rooms each day along with the standard cleaning of resident rooms. The schedule for deep cleaning is located in the Housekeeping Supervisor's office. The housekeeper indicated when she deep cleaned a resident's room she dusted everything on the shelves and pulled the furniture away from the walls. She indicated she completed the same routine tasks for deep cleaning of the bathrooms.</p> <p>During an interview with the Housekeeping Supervisor on 5/30/12</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155363	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PROFESSIONAL CARE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 404 W WILLOW RD DALE, IN 47523
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>8:01 A.M., in room 25's bathroom, he indicated the floors were not clean and said, "housekeeping should take a scraper with a towel wrapped around it to clean those corners and threshold." The Housekeeping Supervisor also indicated the housekeeping staff is instructed to report any necessary repairs directly to him and he reports the repairs to maintenance.</p> <p>3.1-19(f)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155363		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/30/2012	
NAME OF PROVIDER OR SUPPLIER PROFESSIONAL CARE REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 404 W WILLOW RD DALE, IN 47523			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure side rail gaps between the headboard and the top of the rail were measured and assessed for 1 of 5 residents' beds reviewed. Resident # 5</p> <p>Findings include:</p> <p>On 5/25/12 at 8:45 A.M., Resident #5's bed was observed. Both upper side rails (looked like enabler/grab bars) were in the up position. The side rails were observed to be in an inverted "U" shape and were bolted to each side of the bed near the head of the bed. One side of the bed was up against the wall. The resident was not in bed. The HOB (head of the bed) was in the down position and flat. The gap area between the edge of the top of the headboard and the top of the side rail on the side of the bed against the wall measured 9 inches with a standard ruler. The other side of the bed had a gap which measured 6 and 1/4 inches from the</p>	F0323	Resident # 5 use of siderails was re-assessed and found they could be removed. An assessment of in house residents using siderails will be completed to ensure there are no entrapment zones. All staff will be re-educated to properly assess side rail use for potential entrapment zones. Residents with side rails will be assessed for potential side rail entrapment zones weekly x 2 weeks then monthly x 6 thereafter. Results of the above audits will be forwarded to the QPI committee for review and further recommendations as deemed appropriate until resolved. Responsible persons are HFA and IDT	06/29/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155363	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PROFESSIONAL CARE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 404 W WILLOW RD DALE, IN 47523
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>top of the headboard to the top of the side rail.</p> <p>On 5/25/12 at 11:17 A.M., the Administrator and the Director of Nursing (DON) were made aware of the side rail gap measurements. At this time the DON indicated the side rails on Resident #5's bed were considered by the facility to be 1/4 side rails.</p> <p>On 5/25/12 at 11:30 A.M., Resident #5's clinical record was reviewed. A Safety Device Data Collection document had been completed on 2/29/12. This documentation addressed the safety device of "Bed next to the wall." Documentation was lacking of a side rail assessment. The resident's current Minimum Data Set Assessment Summary (MDS) dated 3/29/12, indicated a cognitive score which indicated moderate impairment with decisions poor and supervision and cueing required.</p> <p>On 5/29/12 at 8:05 A.M., the Administrator and the DON were interviewed regarding an assessment lacking in regard to the side rails on the bed of Resident #5. The Administrator indicated Resident #5 had been moved into his current room approximately 3 weeks ago. The</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155363		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/30/2012	
NAME OF PROVIDER OR SUPPLIER PROFESSIONAL CARE REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 404 W WILLOW RD DALE, IN 47523			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>facility didn't move Resident #5's bed but moved him into the bed already in his new room.</p> <p>On 5/29/12 at 8:30 A.M., Resident #5's clinical record was again reviewed. A telephone order with a clarification order date of 5/25/12, indicated to discontinue side rails due to non use.</p> <p>On 5/25/12 at 12:26 P.M., a facility policy entitled Safety Device Program (policy date 1/2009) was received and reviewed. Procedure: "...will use a safety device as indicated , to maintain a resident's highest practicable well-being... ..devices are not necessarily without risk so, it is important to weigh the relative risk and benefit of using certain devices..."</p> <p>"...Assistance/Assistive devices is defined as any device used by or in care of a resident to promote, supplement, or enhance the resident function and/ or safety e.g., handrails, grab bars..."</p> <p>"... Bed rails and bed accessories can pose increase risk to resident safety."</p> <p>"...safety devices increase the risk of entrapment..."</p> <p>The <u>Hospital Bed System Dimensional and Assessment</u></p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155363	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PROFESSIONAL CARE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 404 W WILLOW RD DALE, IN 47523
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p><u>Guidance to Reduce Entrapment-Guidance for Industry and FDA Staff</u> issued March 10, 2006 indicates the FDA (Food and Drug Administration) recommends openings within the rail, between rail supports, under the rail or next to a single rail support and between the rail and mattress should be small enough to prevent the head from entering or being entrapped. The " Hospital Bed Safety WorkGroup (HBSW) " and the " International Electrotechnical Commission (IEC) " along with the FDA recommend the space be less than 4 ¾ inches.</p> <p>The FDA recommends the space under the rail- at the ends of the rail be small enough to prevent neck entrapment. The HBSW and the IEC along with the FDA recommend this space be less than 2 3/8 inches and greater than a 60 degree angle.</p> <p>3.1-45(a)(1)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155363		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/30/2012	
NAME OF PROVIDER OR SUPPLIER PROFESSIONAL CARE REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 404 W WILLOW RD DALE, IN 47523			
(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			
F0325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on interview and record review, the facility failed to ensure the weights of a recently admitted resident and requiring anti-nausea medication were monitored for 1 of 4 residents reviewed who met the criteria for nutrition. Resident #55</p> <p>Findings include:</p> <p>The clinical record of Resident #55 was reviewed on 5/25/12 at 10 A.M. The resident was admitted to the facility on 3/23/12. Diagnoses included, but were not limited to, the following: hypertension, diabetes mellitus and recent hip fracture. The "Weight Detail Report" included the following weights for 2012: 3/23 = 255.6 lbs.; 4/4 = 231.2 lbs.; 4/4 = 231.2 lbs.; 4/30 = 222.8 lbs.; 5/6 = 222.8 lbs.; 5/9 = 220.4 lbs.</p>	F0325	<p>The physician of resident # 55 was notified and orders received for weight loss interventions. Resident has been placed on weekly weights until weight stabilizes. A medical record review of current in-house residents has been completed to ensure residents are being weighed per physician orders and per center policy. Licensed nurses and IDT will be re-educated on policy & procedure for obtaining weights to include but not be limited to obtaining weights on admission & re-admission. The medical record of newly admitted or re-admitted residents will be reviewed by the IDT to ensure resident weights are obtained per physician order and per center policy. Review will be completed daily x 72 hours then weekly x 4 weeks. DON/designee will review a 10% random sample of residents medical records to ensure</p>	06/29/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155363		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/30/2012	
NAME OF PROVIDER OR SUPPLIER PROFESSIONAL CARE REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 404 W WILLOW RD DALE, IN 47523			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>On 5/25/12 at 2:12 P.M., the DON (Director of Nursing) was interviewed. She indicated the above weights were accurate including, but not limited to, the following: the 24.4 lb weight loss from 3/23/12 to 4/4/12. She indicated the re-weight on 4/4/12 of 231.2 lbs. was correct. She indicated after admission the resident was to be weighed weekly for 4 weeks, then monthly. The DON indicated the resident was transferred back to the hospital on 4/15/12 with a diagnosis of acute renal failure. She indicated the resident returned to the facility on 4/24/12.</p> <p>On 5/29/12 at 9 A.M., the plan of care for Nutrition at Risk was reviewed. This had an original date of 3/24/12. Interventions included, but were not limited to, the following: concentrated carbohydrate diet, double protein (4/11/12), monitor weights x 4 weeks.</p> <p>On 5/29/12 at 9:10 A.M., the Nutrition Risk Data Collection and Assessment was reviewed. This form was dated initially 3/23/12. The form indicated the following: ideal body weight 160 lb - 196 lb; on 4/4/12 noted by the dietician: "Res (resident) has not had a new wt (weight) recorded in care tracker...."</p>		<p>resident weights are obtained per physician order and per center policy weekly x 4 weeks and monthly thereafter. Results of above audits will be forwarded to the QA committee monthly ongoing for review and recommendations as deemed appropriate. Responsible persons are HFA and IDT</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155363	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/30/2012
NAME OF PROVIDER OR SUPPLIER PROFESSIONAL CARE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 404 W WILLOW RD DALE, IN 47523		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>On 5/29/12 at 9:15 A.M., the physician progress note dated 3/27/12 was reviewed. This note included but was not limited to, the following: "nausea, this might be related to some of his pain medications, as this is a new issue for him...."</p> <p>On 5/29/12 at 9:30 A.M., the Dietary progress notes, dated 5/1/12, were reviewed. These included, but were not limited to, the following: "...recently returned from hospital stay r/t (related to) ARF (acute renal failure), sepsis, acute encephalopathy...."</p> <p>On 5/30/12 at 8:20 A.M., the DON provided a current copy of the facility policy and procedure for "Weight Monitoring." The policy and procedure was dated 4/2010. This policy included, but was not limited to, the following: "Weigh each resident within 24 hours of admission...Weigh the resident the first three days of admission...or until accuracy has been verified by the licensed nurse. Weigh the resident weekly for four weeks and/or until the weight is determined to be stable by the interdisciplinary team following admission...Verify accuracy of the weight by comparing the weight with</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155363	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PROFESSIONAL CARE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 404 W WILLOW RD DALE, IN 47523
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the most recently recorded weight; Compare weights using the Weight Change Grid to determine 3% weight change...monitor weight reports for significant changes...review significant weight change reports daily for review in Daily Triage Meeting. Review the weight reports at least weekly to assure that all residents with significant weight changes are reviewed and assessed..."</p> <p>On 5/30/12 at 9:30 A.M. the DON was interviewed. She indicated the Weight Detail Report had all the resident's weights documented. She indicated the resident was not weighed from his admission on 3/23 until 4/4/12. She indicated the reason for this was on admission the resident had not had an order written for weekly weights x 4 weeks. The first weight after the admission weight was on 4/4/12 with a result of 231.2 lbs. She indicated the resident was very nauseated and had an order for phenergan on 3/27/12. The April medication administration record was reviewed and indicated the resident received the phenergan on the following dates: 4/1 x2, 4/2, 4/3, 4/4, 4/14 x2 and 4/15 x2. The DON indicated the resident received an order for double protein on 4/10/12. The DON provided a current weight</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155363	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PROFESSIONAL CARE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 404 W WILLOW RD DALE, IN 47523
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>log which indicated the most recent weight of 223.2 lb on 5/14/12. The DON indicated the physician should have been notified of the 24.4 lb. weight loss from 3/23/12 until the 4/4/12 weight but documentation was lacking of him being notified. She indicated she feels sure the Nurse Practitioner was notified but the DON doesn't have documentation of this.</p> <p>3.1-46(a)(1)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155363	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PROFESSIONAL CARE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 404 W WILLOW RD DALE, IN 47523
---	--

(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
F0329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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 record review and interview, the facility failed to ensure the use of hypnotic drugs were necessary for 1 of 10 residents reviewed for unnecessary drug use. Resident #54</p> <p>Findings include:</p> <p>The clinical record of resident of Resident # 54 was reviewed on 5/29/12 at 1:30 P.M. It indicated the resident had diagnoses of</p>	F0329	Resident #54 hypnotic was discontinued and non-pharmacological interventions were put in place.A medical record review of all in house residents using hypnotics will be completed to ensure non-pharmacological interventions were put in place prior to ordering hypnotics.Nurses will be re-educated to ensure an assessment and non-pharmacological interventions are put in place prior to ordering hypnotics. IDT will review Residents receiving orders	06/29/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155363	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/30/2012
NAME OF PROVIDER OR SUPPLIER PROFESSIONAL CARE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 404 W WILLOW RD DALE, IN 47523		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>pancreatitis, alcoholism, hepatitis C, and cirrhosis of the liver. There was a physician order on 5/18/12 for Ambien 10 mg at bedtime as needed for sleep.</p> <p>The first notation of difficulty sleeping was in a nurse's progress note of 5/13/12 at 9:45 A.M. The note was "Resident heard fussing at roommate this A.M. States she kept her up all night. Suggested resident find an empty room (in which to sleep) next time."</p> <p>There was a Social Service note made for 5/18/12 which indicated the "Resident requested Ambien- due to stating trouble sleeping. MD ordered prn (as needed) Ambien on 5/18/12. We will continue to assess for better/worse sleeping. Sleep study put into place Friday (5/18/12) with nurse."</p> <p>There was a "Sleep Assessment" form completed by the nurse on 5/18/12. It indicated the information had been gathered from the resident. When the resident was asked "What keeps you awake at night?", she indicated people on the hall yelling kept her awake. Under the heading of environmental factors that apply, the nurse checked "NOISE" and</p>		for hypnotics daily x 4 weeks then monthly x 6 to ensure an assessment and non-pharmacologic interventions have been put in place prior to ordering hypnotics. Results of the above audits will be forwarded to the QPI committee for review and further recommendations as deemed appropriate until resolved. Responsible persons are HFA and IDT		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155363	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PROFESSIONAL CARE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 404 W WILLOW RD DALE, IN 47523
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>wrote the description "Roommate at times wakes her up and other residents on the hall."</p> <p>On 3/30/12 there had been a Care Conference/clinical meeting notes which included "...closely monitoring medication use especially narcotics due to a history of substance abuse...."</p> <p>The Care Plan of 5/21/12 addressed "Potential for side effects related to psychotropic drug use." It indicated the resident had been placed on Ambien (hypnotic) for insomnia. The portion of the care plan with the heading "Non-Drug interventions used:" was left blank. The Care Plan did not address insomnia or provide staff interventions to promote or enhance sleep.</p> <p>The 7 day sleep assessment, completed from 5/18/12 to 5/25/12, indicated the Ambien had been given every night and the resident continued to be awake without greater than 4-6 hours of sleep or as little as 2 hours in any 24 hr period.</p> <p>On 5/24/12 there was a progress note from Social Service indicating the resident had requested to be moved due to her roommate being very</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155363	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/30/2012
NAME OF PROVIDER OR SUPPLIER PROFESSIONAL CARE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 404 W WILLOW RD DALE, IN 47523		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>demanding of her.</p> <p>As of 5/30/12 at 11:00 A.M. documentation was lacking to indicate there had been any insomnia related interventions implemented since the sleep assessment was completed and the room change occurred. Documentation was also lacking to indicate how the resident was sleeping since.</p> <p>On 5/30/12 at 1:00 P.M. the Director of Nursing and Social Service Director were interviewed and indicated understanding of the problem regarding the use of the Ambien.</p> <p>3.1-48(a)(6)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155363		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/30/2012	
NAME OF PROVIDER OR SUPPLIER PROFESSIONAL CARE REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 404 W WILLOW RD DALE, IN 47523			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F0465 SS=C	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORT ABLE 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 and interview, the facility failed to provide a sanitary environment in 1 of 1 pantry serving 2 of 2 nursing units, potentially affecting 42 of 42 residents.</p> <p>Findings include:</p> <p>On 5/30/12 at 12:50 P.M. the facility pantry was observed. It included a full sized refrigerator which was full of foods and beverages for residents. It had accumulated food matter, dried spills, tacky surfaces and hand soil inside and on exterior surfaces. The lower portion of the gasket on the lower door was ripped and dragging the floor with dust and debris hanging on it. The freezer section was frosted with a 2 inch thick depth of ice.</p> <p>The microwave interior was heavily soiled with accumulated dried food spatters. The exterior door was handle area was coated with oily/sticky matter.</p> <p>The floor was heavily soiled with dirt, food debris and dust, especially in corners and pushed to the edges.</p>	F0465	<p>The pantry was deep cleaned 5-30-12. The microwave was replaced 6-5-12. The refrigerator was deep cleaned 6-14-12. The refrigerator will be replaced. The pantry flooring has been placed on a schedule to be repaired and stripped/waxed. The ceiling and walls have been placed on a schedule to be painted. The exhaust fan in the pantry will be repaired or replaced. All Housekeeping staff have been Re-educated regarding the 5-7 step deep cleaning process and wet/dry mopping floors. All staff have been re-educated to fill our work orders for items needing cleaning. The refrigerator, floors and microwave in the pantry will be added to the daily cleaning schedule and the monthly deep clean schedule. NHA will audit the pantry floors, refrigerator and microwave daily x 4 weeks then weekly x 4 then monthly x 6 thereafter to ensure it is clean, safe and in good repair. Results of the above audits will be forwarded to the QPI committee for review and further recommendations as deemed appropriate until resolved. Responsible persons are HFA and Housekeeping Supervisor.</p>	06/29/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155363	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PROFESSIONAL CARE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 404 W WILLOW RD DALE, IN 47523
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>There was a missing section of the floor tile in front of the sink cabinet.</p> <p>The ceiling fan was functioning only at intervals and when blades revolved there was a clattering sound. The room was dank with musty odor.</p> <p>There were dark brown spatters dried on the ceiling.</p> <p>On 5/30/12 at 1:00 P.M. the Administrator indicated the pantry was included on a cleaning schedule and had been deep cleaned a month ago.</p> <p>3.1-19(f)</p>			