STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155376	A. BUILDING 00 B. WING	07/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HEALTHCARE OF SHERIDAN	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
F 0000 Bldg. 00		F 0000		

This visit was for the Investigation of Complaints IN00228151 and IN00233523.

Complaint IN00228151 - Substantiated. Federal/State deficiencies related to the allegations are cited at F431.

Complaint IN00233523 - Substantiated. Federal/State deficiencies related to the allegations are cited at F465.

Survey date: July 11 and 12, 2017

Facility number: 000336
Provider number: 155376
AIM number: 100290170

Census bed type:
SNF/NF: 38
Total: 38

Census payor type:
Medicare: 2
Medicaid: 32
Other: 4
Total: 38

These deficiencies reflect State findings cited in accordance with 410 IAC

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

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	16.2-3.1. Quality Review was completed on July 14, 2017.			
F 0431 SS=F Bldg. 00	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals.			

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	Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on interview and record review the facility failed to ensure the reconciliation of controlled drugs in 4 of 4 medication carts reviewed for controlled drugs. This practice had the potential to affect 38 out of 38 residents receiving medications in the facility. Findings include: 1.) During the record review of controlled drug records on 7/11/2017 at 3:15 p.m., on the 200 Hall North Short medication cart it was found to have 49	F 0431	Please accept this as Premier of Sheridan's alleged compliance for deficiencies reflecting State finding F 431 DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICAL on July 11 and 12, 2017. 1. All residents narcotic logs were audited for missing signature and corrective action was taken. 2. All residents on 100 hall and 200 hall narcotic logs were	08/11/2017

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	entries missing for the reconciliation of controlled drugs for the month of May, 37 entries for the month of June and 16 entries for the month of July until the 11th, 2017. 2.) During the record review of controlled drug records on 7/11/2017 at 3:20 p.m., on the 200 Hall North Long medication cart it was found to have 43 entries missing for the reconciliation of controlled drugs for the month of May, 26 entries for the month of June and 21 entries for the month of July until the 11th, 2017. 3.) During the record review of controlled drug records on 7/11/2017 at 3:28 p.m., on the 100 Hall South Short Long medication cart it was found to have 21 entries missing for the reconciliation of controlled drugs for the month of May, 42 entries for the month of June and 13 entries for the month of July until the 11th, 2017. 4.) During the record review of controlled drug records on 7/11/2017 at 3:32 p.m., on the 100 Hall North Long medication cart it was found to have 19 entries missing for the reconciliation of controlled drugs for the month of May, 31 entries for the month of June and 9 entries for the month of July until the		audited for errors. Medications were counted and compared to narcotic log sheet to ensure proper count. All log sheets were audited for signatures and needed documentation. Findings were reported to the Director of Nursing. Any discrepancies note was immediately investigated and corrected. 3. In-service for the nursing staff will be conducted on the"Controlled Substances" policy and procedure with a signature of attendance. The daily on going task of auditing the narcotic logs will be added to the Unit Manager and Weekend Manager responsibilities. All findings will be immediately reported to the Director of Nursing for review. All deficient findings will be investigated with documentation and deficiencies corrected immediately. 4. Narcotic log audit sheets will be reviewed by the Director of Nursing or designee on a weekly basis X 4 weeks, then biweekly X 4 weeks, then monthly according to the CQI schedule to ensure continued compliance.	

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	11th, 2017. During an interview on 7/12/2017 at 2:30 p.m., with LPN 6 he indicated the reconciliation records for controlled drugs are signed when you count the controlled drugs before each shift and after the shift is over and the controlled drugs are recounted. The count must be conducted with another nurse and must be accurate or it is reported to the supervisor. During an interview on 7/12/2017 at 2:38 p.m., with LPN 7 she indicated the reconciliation records for controlled drugs are signed when you count the controlled drugs before each shift and after the shift is over and the controlled drugs are recounted. The count must be conducted with another nurse and must be accurate or it is reported to the supervisor. During an interview on 7/12/2017 at 2:40 p.m., with LPN 8 she indicated the reconciliation records for controlled drugs are signed when you count the controlled drugs before each shift and after the shift is over and the controlled drugs are recounted. The count must be conducted with another nurse and must be accurate or it is reported to the supervisor.		All finding will be reported to the IDT and if needed a POC will be reviewed during the monthly CQI meeting. 5. Date of Compliance 8/11/2017	

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	During an interview on 7/11/2017 at 4:15 p.m., with the Director of Nursing, she indicated the reconciliation records for controlled drugs are signed when you count the controlled drugs before each shift and after the shift is over and the controlled drugs are recounted. The count must be conducted with another nurse and must be accurate or it is reported to the supervisor. All records should be signed. The current policy titled "Controlled Substances" dated December 2012, received on 7/11/2017 at 5:15 p.m., from the Executive Director indicated "... (. Nursing staff must count medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services....." This federal tag relates to the complaint IN00228151. 3.1-25(m) 3.1-25(n)			
F 0465 SS=F Bldg. 00	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON			

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	(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. Based on observation, record review and interview, the facility failed to ensure a clean, sanitary, and home like environment related to 8 of 8 resident rooms, hallways, shower rooms, lounges and dining room (Room's 101, 105, 108, 110, 112, 119, 213 and 214). Findings include; 1. During the initial tour on 7/11/2017 at 3:05 a.m., the following was observed: a.) The bedroom doors and entrance arch ways for rooms 101, 105, 108, 110, 112, 119, 213 and 214 were gouged, chipped and peeling. b.) The exit doors for the facility hallways (x4) were marred, chipped and peeling and the floor boards had dirt and debris. c.) The pocket area behind the handrails in the facility contained dirt, debris and	F 0465	Please accept this as Premier of Sheridan's alleged compliance for deficiencies reflecting State finding F 465 SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT on July 11 and 12, 2017. 1. The Resident rooms that were identified, (101, 105, 108, 110, 112, 119, 213, 214) as needing paint and repair to door archways, the walls, the, floors, and the closet doors, have been painted and repaired. The Resident rooms that were identified, (101, 105, 108, 110, 112, 119, 213, 214) as needing windows and window ledges cleaned of cobweb and debris have been cleaned. The Shower room on 100 hall and 200 hall that was identified as needing repairs on the floors and the toilet area	08/11/2017

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	food. d.) The shower area for the 100 hall floor was cracked, chipped and gouged, the toilet tank top was not secured, the floor toilet tank screw was not covered and rusted and 3 of 3 overhead lights were noted to have dirt, bugs and debris. e.) The shower areas (x2) for the 200 hall floor was cracked, chipped and gouged, and the floor was noted to have dirt and debris. f.) The lounge area on the 100 hallway air vents (x2) were covered in dirt and debris. g.) The dining room entry pillars (x4) were chipped, cracked and peeling and the fan opposite the dining room area had dirt and debris on the vents. h.) The hallway floor for the 100 hallway was chipped, cracked, and had divots (x3) which had dirt and debris in the divots. i.) The hallway floor for the 200 hallway was chipped and cracked. 2. During resident room observations on 7/11/2017 and 7/12/2017, the following was observed:		have been repaired. The toilet was re-secured and the floor was repaired with self leveling concrete. The Shower room on 100 hall and 200 hall that was identified as needing cleaning of the floors and light fixtures have been cleaned. The common areas identified (exit doors, lounge area, dining room entry pillars, and hallways) as needing paint and repairs have been painted and repaired. The common areas identified (air vents) that needed to be cleaned of dust and debris have been cleaned. 2. All Resident rooms will be immediately inspected by the Premier CARE representative and finding reported to the Maintenance Director, Housekeeping Director and the Administrator. All common areas will be immediately inspected by the Maintenance and Housekeeping Director and finding reported to the Administrator. A daily task assignment will be completed by the Maintenance Director,	

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	a.) Room 105 on 7/12/2017, at 2:30 p.m., the bedroom wall was chipped, cracked and had multiple holes. b.) Room 101 on 7/11/2017, at 4:45 p.m., the bedroom wall was chipped, cracked and peeling. c.) Room 108 on 7/12/2017 at 2:49 p.m., the bedroom floor was chipped and cracked. d.) Room 110 on 7/11/2017 at 5:18 p.m., the window ledge had cobwebs and debris and the window blinds were dirty with dust and debris. e.) Room 112 on 7/11/2017 at 3:50 p.m., the window ledge had cobwebs and debris and the 3 closet doors were off the tract and had door knobs missing. f.) Room 119 on 7/12/2017 at 2:58 p.m., the floor mat along side the bed was stained and dirty. On 7/12/2017 at 3:30 p.m., the Executive Director indicated the facility had a reporting system for all staff to notify the Maintenance Department of facility needed repairs and housekeeping issues. The Executive Director indicated she was not aware of the facility needing these		Housekeeping Director and the Administrator to ensure compliance date is met. Repairs, painting and cleaning will be performed by the Environmental team. 3. A resident room inspections log has been developed and implemented to be completed by the Premier CARE representative on a monthly basis and findings reported to the Maintenance and Housekeeping Director. A rotation schedule will be created to ensure there is a workable schedule to maintain compliance. 4. The Maintenance Director, Housekeeping Director and the Administrator will review the inspection logs on a weekly basis X 4, then biweekly X 4, then monthly according to the CQI schedule to ensure continued compliance. All finding will be reported to the IDT and if needed a POC will be reviewed during the monthly CQI meeting. 5. Date of Compliance 8/11/2017	

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	repairs or that areas were in need of cleaning by housekeeping. She indicated she was aware of the doors and entrance ways needing repair and had reported the issue to the corporate office in January 2017. Repairs had not had been completed or financed for the 2017 year. The current policy titled "Environmental Improvement Policy", undated, received on 7/12/2017 at 3:00 p.m., from the Executive Director indicated "...4. The Premier CARE representative reviews rooms daily as assigned by administrator and brings forward any environmental concerns 5. Immediate or emergent environmental concerns are reported directly to the supervisor and maintenance is notified and the administrator is responsible to oversee and communicate progress to the IDT as needed ...." This federal tag relates to the complaint IN00233523. 3.1-19(f)			