STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
F000000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00156811. Complaint IN00156811-Substantiated with no deficiencies. Survey dates: November 5, 6, 7, 10, 12, 13, and 14, 2014. Facility number: 000157 Provider number: 155254 AIM number: 100274720 Survey Team: Tom Stauss, RN, TC Beth Walsh, RN Karina Gates, Generalist Census Bed type: SNF/NF: 47 Total: 47 Census Payor type: Medicare: 3 Medicaid: 38 Other: 6 Total: 47 These deficiencies reflect State findings	F000000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
	cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 19, 2014 by Cheryl Fielden, RN.			
F000166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. Based on interview and record review, the facility failed to follow up with Resident Council, after grievances were voiced at a council meeting regarding housekeeping concerns. This had the potential to affect 7 residents in attendance at the council meeting. (Residents #5, 20, 27, 50, 62, 67, and 73) Findings include: An interview was conducted with the Resident Council President, Resident #67, on 11/10/14, at 11:30 a.m. Regarding whether facility staff listened to the council's views and acted upon any grievances the group filed, Resident #67 indicated, "No." She stated, "We've discussed how housekeeping does not do a good job in our rooms. One lady doesn't sweep, or mop floors, or dust. She'll only take the trash out, but she'll	F000166	Sugar Creek Rehabilitation has reviewed its current practice of addressing Resident Council grievances, and the following changes have been made; copies of all Resident Council concerns will be provided to the Administrator or designee to ensure follow up is provided to the concerned party in a timely manner. Resident Council Meeting Minutes were reviewed for the preceding 12 months; no other concerns were found to have not been addressed timely, therefore all residents had the potential to be affected, however no residents were identified as affected by the deficient practice. Sugar Creek Rehabilitation has revised the Resident Council concern form, which will require at least 3 signatures; a signature of the department related to the grievance, either the SSD or Activity Director, and the Administrator or designee.	12/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
	put a sign out that says "wet floor." They need to dust the furniture, sweep under the bed, clean the back of the toilet and the sink. It gets dusty in here really fast. We've talked about this at the last council meeting. (Name of Resident #20) also complained about that." The Activity Director (AD) provided copies of the August, September, and October, 2014 Resident Council Minutes on 11/10/14, at 12:09 p.m. The August, 2014 minutes indicated, "Concerns/Comments: (Concern forms completed) Housekeeping: floors look bad, really dirty." The September, 2014 minutes did not indicate any follow up to the August, 2014 housekeeping concerns. They indicated, "Concerns/Comments: (Concern forms completed) Housekeeping: Not dusting, floors not being done, building looks bad." The October, 2014 minutes did not indicate any follow up to the September, 2014 housekeeping concerns. They indicated, "Concerns/Comments: (Concern forms completed) Housekeeping: Staff-some not doing as they need." An interview was conducted with the Activity Director, who took minutes at council meetings, on 11/10/14, at 12:09 p.m., regarding the 3 months worth of housekeeping concerns, and whether		The Activity Director or designee will review the completed Resident Council Concern form with the President of the Resident Council and as needed with the resident whom voiced the concern. The Resident Council meeting minutes and all resident council concern forms will be reviewed at the Daily QA meeting, within 7 days of the Resident Council meeting to ensure all concerns have been addressed timely. This will be an on-going process to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
	concern/grievance forms were completed for these concerns. She indicated, "I wrote up a resident council concern report, and gave it to (name of previous housekeeping manager.) She filled in the follow up." Regarding whether she or anyone followed up with Resident Council regarding their concerns, she indicated, "As far as I know, I'm done after I gave it to the department. The Social Services Director (SSD), the Administrator, and the responsible staff (in this case housekeeping) would sign. The SSD is the only one still here." She indicated the September, 2014 council minutes did not reference previous concerns. She stated, "The department manager should have followed up. (Name of the previous housekeeping manager) was asked by (name of Resident #67) to come to the September meeting. (Name of Resident #67) told me she invited her. By the 9/4/14 meeting, (name of previous housekeeping manager) no longer worked here in the daytime, and we had no housekeeping manager. No housekeeping staff came to the September meeting to address the August concerns of dirty floors." Regarding the September, 2014 housekeeping concerns referenced in the council minutes, she indicated, "In September, when the housekeeping concerns were brought up again, I filled			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
	out another grievance form, and put it in (name of previous housekeeping manager's) mailbox. That's where it ended with me. When I completed the August and September grievance forms, I gave one to (name of previous housekeeping manager) and one to the Administrator." She indicated the current Administrator began on 10/20/14, so the 2 housekeeping grievances were given to 2 previous administrators. She indicated she did not keep copies of the grievance forms she completed. An interview was conducted with the Administrator on 11/10/14, at 12:43 p.m., regarding whether she knew of any housekeeping grievance forms passed onto her from previous administrators. She indicated, "I haven't received any grievance forms in relation to floors. I'll look. I asked (name of Activity Director) for council minutes for the last year. She gave them to me, and I haven't had a chance to look at them." An interview was conducted with the SSD on 11/10/14, at 1:54 p.m. She indicated, "I have never been given any grievances from resident council, ever." The SSD looked through her grievance log, and stated, "No, I don't have anything at all on housekeeping or dirty floors. I don't have anything from (Name			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of Resident Council President), at all. I handle all resident grievances, outside of resident council." Regarding who was responsible for handling resident council grievances, and the process for follow up with resident council grievances, she indicated, "I assume resident council would be handled the same way, but I have not had anything to do with those, historically." The SSD reviewed her grievance log again, and found 2 resident council grievances from July, 2014 regarding dietary and missing shirts. She stated, "It looks like I did sign off on these." An interview was conducted with Resident #67 on 11/10/14, at 2:17 p.m., regarding whether staff ever followed up with council regarding the housekeeping concerns. She stated, "No one ever came back to resident council in September or October, about the housekeeping issues from August or September." The Grievances and Concerns policy was provided by the ADON (Assistant Director of Nursing) on 11/12/14, at 9:18 a.m. It indicated, "The initiated grievance form shall be given to the Social Services Director. The Social Services Director shall review the grievance form and forward the grievance to the most applicable department for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
	investigation. A complete investigation of the grievance shall be completed and documented on the form. Steps to resolve the grievance should be determined and documented on the grievance form. The grievances form should then be returned to the Social Services Director for review and follow up with the Resident and/or responsible party. All grievances shall be reviewed by the facility Administrator and logged on grievance log. All grievances should be handled in a timely fashion with typical resolution to be sought within 5-7 days." 3.1-7(a)(2)			
F000250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility failed to assist an edentulous resident with impaired vision in retrieving dentures and glasses for 1 of 3 residents reviewed for dental status and services, and 1 of 1 resident reviewed for vision. (Resident #9) Findings include:	F000250	The SSD has made several attempts to contact Resident #9's family, with no resolution. The facility will schedule Resident #9 with optical and dental services during the next routine visit by facility's preferred provider. An audit will be completed of all residents in regards to optical and dental services; any resident identified in need of service will be referred to the facility's preferred provider or other	12/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The clinical record for Resident #9 was reviewed on 11/7/14, at 10:00 a.m. The diagnoses for Resident #9 included, but were not limited to, edentulous and poor vision. An interview was conducted with Resident #9 on 11/7/14, at 10:31 a.m. He indicated, "My dentures are in my sister's car, and she doesn't answer the phone. I gum my food. It would be great to have my dentures. My contact lenses and glasses are in there, too. I need those too. One eye is blurry. The left is fine." He provided his sister's phone number at this time. The 7/5/14 Admission Nursing Assessment indicated he had poor vision, and his glasses were not with him. The Oral Cavity section of the assessment indicated Resident #9 was edentulous. The 7/12/14 Admission MDS (minimum data set) assessment indicated Resident #9 was not edentulous and had adequate vision. The Oral/Dental Status Section of the MDS 3.0 Manual was provided by the MDS Coordinator on 11/12/14, at 1:00 p.m. It indicated, "Ask the resident, family, or significant other whether the resident has or recently had dentures or		appropriate provider of optical and dental services. Attachment A. All residents will be assessed upon admission for Medically related Social Service needs and at least quarterly thereafter during routine care plan meetings. The Administrator or designee will audit the initial Social Service assessment after completion by the SSD, to ensure all residents medically related social service needs are met. The audits will be reviewed during the QA meeting for 6 months, and the QA committee will determine if there is a need for continued monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
	partials. (If the resident or family/significant other reports that the resident recently had dentures or partials, but they do not have them at the facility, ask for a reason." An interview was conducted with Resident #9 on 11/12/14, at 10:31 a.m. He indicated, "My glasses are in my car. When they (facility staff) did the assessment on me, I told them there's no point in doing it, because I don't have my glasses." An observation of Resident #9 was made with the MDS Coordinator on 11/12/14 at 11:20 a.m. He had no teeth, dentures, or glasses. Resident #9 indicated, "My glasses are bifocals, so they help me read the newspaper faster. I can still read the paper, I'm just slower." He indicated he "gummed" his food. The MDS Coordinator indicated, "He may have said he didn't have his glasses with him, but not that he couldn't see....The dentist was here yesterday. I'm going to get with the Social Services Director (SSD), and see if he can be seen by the dentist and about his glasses and dentures being in the sister's car. An interview was conducted with the SSD on 11/12/14, at 2:01 p.m. She indicated, "I left 2 messages with his			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
	sister about his belongings. I didn't know anything about this before today. He was not seen by the dentist yesterday, and has never been seen. Usually, during MDS assessments, they let me know if they want to be seen." Another interview was conducted with the SSD on 11/14/14, at 10:40 a.m., regarding why no one attempted to assist Resident #9 with retrieving his glasses and dentures, given his 7/5/14 admission date. She indicated, "No one told me about his missing glasses or dentures. It falls on me to follow up with his sister to try and get them." 3.1-34(a)			
F000253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to provide a home-like environment for 4 of 30 residents reviewed for home-like environment (Resident #'s 19, 27, 63, & 65) Findings include: 1. During a random observation of Resident #27, #19, and #63's room, on	F000253	The bathroom tiles located in the bathroom for residents #19, #27 and #63, as well as the flooring in the bathroom for resident #65, is scheduled to be replaced within the next 60 days. The wall in resident #65's room will be cleaned and painted within the next 60 days. An audit will be conducted of all resident bathroom floor tiles and resident room walls, including bathroom walls. A list will be compiled of all	12/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
	11/6/14 at 11:59 a.m., several tiles at the entrance of the bathroom were noted to have thick dark colored debris on them. On several bathroom tiles, a gray substance was observed. On 11/10/14 at 11:55 a.m., the same observations of Resident #27, #19, and #63's bathroom entrance/bathroom tiles were noted, as above. During an environmental tour with the Maintenance Director, on 11/12/14 at 2:50 p.m., the Maintenance Director indicated he didn't know the bathroom entrance tile or the bathroom tile were in disrepair. The Maintenance Director indicated the tile can be easily replaced. The Maintenance Director further indicated the tile observed did not provide a home-like environment for the Residents. 2. During a random observation of Resident #65's room, on 11/6/14 at 11:40 a.m., several finger length black marks were observed on the wall near Resident #65's bed. Several of Resident #65's bathroom tiles were observed with a gray substance on them. On 11/10/14 at 11:50 a.m., the same observations as above, were made of Resident #65's wall and bathroom tiles.		findings and the work will be scheduled. Attachment B. A deep cleaning schedule was developed for all residents' rooms and bathrooms to ensure sanitary, orderly, and comfortable interior for all residents. This will be an ongoing cleaning schedule on a 9 week rotation. After completion of each deep clean, an audit sheet will be completed by the Housekeeping Supervisor or designee, and then reviewed during the Daily QA meeting. Additionally the Administrator or designee will complete weekly environmental round audits, this will be reviewed during the QA committee meetings. This will be an on-going process to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an environmental tour with the Maintenance Director, on 11/12/14 at 2:57 p.m., the Maintenance Director indicated he was unaware of the black marks on the wall of Resident #65 room or the gray substance on the bathroom tiles. The Maintenance Director indicated both concerns can be fixed. The Maintenance Director further indicated he had not been in the Maintenance Director position long, but he viewed the facility and Resident's rooms/bathrooms as a Resident's home, so he planned to ensure Resident's rooms/bathroom were in good repair. 3.1-19(f)(5)			
F000278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
	who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.			
	Based on observation, interview iew, and record review, the facility failed to ensure accuracy of the MDS (minimum data set) assessment regarding oral status 1 of 3 residents reviewed of 4 who met the criteria for dental status and services. (Resident #9) Findings Include: 1) Resident #11's record was reviewed on 11/7/14 at 11:18 a.m. The resident's diagnoses included, but were not limited to, depression and neuropathic pain. Physician's orders for November of 2014 included an order for Cymbalta for a "..Dx: (diagnosis) Depression..." A psychiatric progress note, dated 11/3/14, did not indicate a diagnosis of depression for Resident #11. The note indicated a "Depression Score" of "0/27"	F000278	The MDS assessment for Resident #9 was updated to reflect an accurate oral status. The Physician orders and care plan for Resident #11 was clarified to reflect an accurate diagnosis for the prescribed medication. An audit of all residents' current oral status' will be conducted to ensure accurate documentation. An audit of all psychotropic medications will be conducted to ensure accurate supporting diagnosis. Attachment C. The MDS Coordinator will be in serviced regarding accuracy of the MDS assessment. The DON or designee will audit three MDS's each week to ensure accurate oral status, for 6 months. The audits will be reviewed during the QA meeting for 6 months, and the QA committee will determine if there is a need for continued monitoring.	12/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
	for Resident #11, which indicated the resident did not have depression. On 11/13/14 at 11:54 p.m., during an interview, the Resident #11's Psychiatrist indicated the use of Cymbalta was for neuropathic pain. On 11/13/14 at 1:11 p.m., during an interview, the MDS coordinator indicated Resident does not have a diagnosis of depression. An email from a pharmacy consultant, undated, indicated Resident #11 "...has been receiving Cymbalta 120mg QD (daily) for neuropathic pain..." and the email indicated the Cymbalta was "...not being used for a psychiatric condition..." 2) The clinical record for Resident #9 was reviewed on 11/7/14, at 10:00 a.m. The diagnoses for Resident #9 included, but were not limited to, bi polar disorder. An interview was conducted with Resident #9 on 11/7/14/14, at 10:31 a.m., regarding whether he had any chewing or eating problems. He indicated, "Yes. My dentures are in my sister's car...I gum my food. It would be great to have my dentures." The 7/5/14 Admission Nursing Assessment for Resident #9 indicated,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
	"Oral Cavity: Edentulous." The 7/12/14 Admission MDS assessment for Resident #9 indicated Resident #9 was not edentulous. An observation of Resident #9's oral cavity was on 11/12/14, at 10:31 a.m. He had no teeth or dentures in his mouth. He stated, "I haven't had teeth or dentures since I got here. I've been gumming it." An interview was conducted with the MDS Coordinator on 11/12/14, at 11:00 a.m., regarding Resident #9's dental status and the accuracy of the 7/12/14 MDS assessment. She indicated, "The nurse does the assessment. I enter it. The 9/10/14 nursing assessment indicates edentulous and missing teeth. He can't have missing teeth and be edentulous. It's one or the other. The MDS should say missing teeth or edentulous. I'm not sure of his dental status. Let's go look." An observation of Resident #9's edentulous status was made with the MDS Coordinator on 11/12/14, at 11:20 a.m. She stated, "The assessment should say edentulous. I'm going to change it." 3.1-31(d) 3.1-31(c)(9) 3.1-31(g)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on observation, interview, and record review, the facility failed to develop a dental/dental services care plan for a Resident with missing/broken teeth for 1 of 3 residents reviewed for dental services. (Resident #1) Findings include: The clinical record for Resident #1 was reviewed on 11/10/14 at 10:15 a.m. The diagnoses for Resident #1 included, but were not limited to, bipolar, schizophrenia, and peptic ulcer disease.	F000279	A dental services care plan has been developed for Resident #1. An audit will be conducted of all residents' oral statues, if any concerns are identified the residents care plan will be reviewed and updated. Attachment C The MDS Coordinator will be in serviced on development and updating of comprehensive care plans. The DON or designee will audit 3 resident care plans per week to ensure that the resident's highest practicable physical, mental, and psychosocial well-being is accurately addressed, for 6 months. The audits will be	12/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an observation of Resident #1's mouth/oral cavity, on 11/7/14 at 1:04 p.m., several missing teeth were noted. Quarterly Nursing Assessments, dated 4/15/14 & 6/24/14, indicated Resident #1 had missing and broken teeth. A review of the Nursing Home Encounter dental visit note for Resident #1, indicated Resident #1 had refused dental services on 2/11/11 and 11/12/13. A Schedule Report Dentistry Visit report indicated Resident #1 refused dental services on 6/3/14. During an interview with LPN #3, on 11/10/14 at 1:26 p.m., LPN #3 indicated Resident #1 has had missing teeth for as long as she could recall. A Dental/Oral Cavity Care Plan or a Refusal for Dental Services Care Plan were not located in the clinical record. The Quarterly MDS (Minimum Data Set) Assessment, dated 9/18/14, indicated Resident #1 was unable to complete the Brief Interview of Mental Status due to missed answers. During an interview with the MDS		reviewed during the QA meeting for 6 months, and the QA committee will determine if there is a need for continued monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR CREEK REHABILITATION AND CONVALESCENT CENT	5430 W US 40 GREENFIELD, IN 46140

(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
	Coordinator, on 11/10/14 at 12:34 p.m., the MDS Coordinator indicated she was unable to locate a Dental Care Plan or a Refusal of Dental Services Care Plan. On 11/13/14, at 9:50 a.m., the MDS Coordinator indicated Resident #1 should have a Dental/Oral Cavity Care Plan and/or Refusal of Dental Services Care Plan because Resident #1 had missing/broken teeth. 3.1-35(a)			
F000280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on observation, interview, and record review, the facility failed to update a care plan with appropriate resident	F000280	Resident #11's care plan has been updated to ensure accuracy regarding the use of Cymbalta for	12/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
	diagnoses for 1 of 30 resident's reviewed for care plans. (Resident #11) Findings include: Resident #11's record was reviewed on 11/7/14 at 11:18 a.m. The resident's diagnoses included, but were not limited to, depression, and anxiety. The resident's medications included, but were not limited to, klonopin, cymbalta, and trazodone. A 10/17/14 MDS assessment indicated Resident #11 had a BIMS score of "15" which indicated she had no significant cognitive impairment. The assessment also indicated the resident had a diagnosis of depression, among other diagnoses, and it indicated the resident took antidepressant medication. On 11/10/14 at 12:18 p.m., Resident #11 was observed being escorted in a hallway by a staff member. The resident was alert, pleasant, and in no distress. On 11/10/14 at 2:06 p.m., during an interview, Resident #11 indicated being satisfied with her medication regimen as ordered by the physician. She indicated having no concerns with pain control or with medication side effects. She also		neuropathic pain. An audit of all psychotropic medications will be conducted to ensure accurate supporting diagnosis. Attachment C. The MDS Coordinator will be in serviced on the development and updating of comprehensive care plans. A Change of Condition form has been implemented to include new orders including those for psychotropic medications; this will be reviewed during the Daily QA meeting. This will be an on-going process to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR CREEK REHABILITATION AND CONVALESCENT CENT	5430 W US 40 GREENFIELD, IN 46140

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated not believing she has depression. On 11/12/14 at 10:55 a.m., Resident #11 was watching television in a wheelchair in her room. She was alert, pleasant, and in no distress. All care planned interventions were in place. A care plan for psychotropic medication use, dated 4/10/14, indicated "...Refer MD to GDR prn..." and "...Medication as per MD order..." and "...AIMS to be completed quarterly..." Other interventions, from a 10/17/14 antidepressant medication care plan, indicated staff should monitor for medication side effects and adverse effects of psychotropic medication use. On 11/13/14 at 9:39 a.m., during an interview, the SSD indicated Resident #11 received Cymbalta for depression and pain. She indicated the resident has received Cymbalta since 1/3/14. She indicated resident #11 has not had any behavioral incidents or reports of behaviors for the resident since 5/28/13. On 11/13/14 at 11:54 p.m., during an interview, the Psychiatrist indicated he was not aware of any side effects or adverse behaviors for which Cymbalta was being used. He also indicated the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
	use of Cymbalta was for neuropathic pain. A care plan, dated 7/21/14, indicated "...Resident (#11) has dx: (diagnosis) depression. Resident has a rx: (prescription) cymbalta..." A psychiatric progress note, dated 11/3/14, indicated Resident #11 was being evaluated for a GDR of "...Klonopin..." The progress note indicated "...No behavior or mood issues noted in recent charting or reported from staff..." The progress note did not indicate a diagnosis of depression for Resident #11. The note indicated a "Depression Score" of "0/27" for Resident #11 which indicated the resident did not have depression. On 11/13/14 at 1:11 p.m., during an interview, the MDS coordinator indicated Resident #11 does not have a diagnosis of depression. She indicated she incorrectly completed a 10/17/14 MDS assessment which identifed Resident #11 as having depression. On 11/14/14 at 9:52 a.m., during an interview, the SSD indicated Resident #11's care plan for depression, along with the Cymbalta use, was an incorrect care plan. She indicated the resident does not			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	have a diagnosis of depression and the care plan should have been updated. 3.1-35(d)(2)(B)			
F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to assess a dialysis resident, in accordance with facility policy, for 1 of 1 resident reviewed for dialysis. (Resident #7) Findings include: The clinical record for Resident #7 was reviewed on 11/13/14, at 10:00 a.m. The diagnoses for Resident #7 included, but were not limited to, end stage renal disease (ESRD). The November, 2014 Physician's Orders for Resident #7 indicated dialysis on Mondays, Wednesdays, and Fridays, effective 1/25/14. There were no assessment orders in regards to assessing Resident #7's dialysis access site.	F000309	Resident #7's dialysis site was assessed for signs/symptoms of infection, no issues were noted. At the time of this Plan of Correction, no other residents were receiving dialysis services. All licensed nurses will be in serviced on the facility policy related to dialysis services, and the assessment of dialysis sites. The assessment of dialysis sites will be documented on the resident's MAR. The DON or designee will audit the pre/post dialysis assessment and site assessment three times weekly for all dialysis residents for 6 months. The audits will be reviewed during the QA meeting, and the QA committee will determine if there is a need for continued monitoring. Attachment D.	12/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The dialysis care plan, with a goal date of 1/1/15, indicated, "Monitor/document/ report to MD PRN (as needed) for s/sx (signs/symptoms) of infection to access site: redness, swelling, warmth, or drainage....Obtain vital signs and weight per protocol. Report significant changes in pulse, respirations and BP (blood pressure) immediately." An interview was conducted with LPN #1 on 11/13/14, at 11:35 a.m., regarding the location of Resident #7's dialysis access site, and how/when she assessed his access site. She indicated, "I think it's on his right arm. He doesn't have orders to monitor his site for signs or symptoms of infection or to check bruit and thrill. I check bruit, thrill and for bleeding precautions. When he comes back (from dialysis), I fill out the assessment sheet." LPN #1 pointed to pre and post dialysis assessment sheets in the MAR (medication administration record) for Resident #7. No 11/3/14 or 11/5/14 assessment was found. The MAR did not indicate daily access site assessments for Resident #7. On 11/13/14, at 11:47 a.m., LPN #1 stated, "I just checked, and he has a permacath in his chest. I just checked it for signs and symptoms of infection, bleeding, that ports were secure. The pre			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and post dialysis assessments are to be filled out before and after dialysis. Dialysis sends a pack with his face sheet and all that. There is a specific dialysis communication form." LPN #1 reviewed Resident #7's clinical record, and pointed out a 9/12/14 dialysis communication form. This was the only dialysis communication form in his clinical record. An interview was conducted with the DON (Director of Nursing) on 11/13/14, at 12:27 p.m. He indicated, "Nursing should be doing pre and post assessments that include: assessing access site for signs and symptoms of infection or bleeding, vitals. We don't have a protocol for doing vitals daily. They should be looking at it at least once a day. We don't have a flow sheet, so I don't expect them to document daily,unless there's something out of the norm. The DON provided dialysis communication forms, that included pre and post assessments, for October and November, 2014. There were no forms for the following dates: 10/6/14, 10/15/14, 10/17/14, 10/20/14, 10/22/14, and 10/24/14. The Care of a Resident with End-Stage Renal Disease policy was provided by the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
	DON on 11/13/14, at 12:30 p.m. It indicated, "Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. Education and training of staff includes, specifically: ...The type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis." An interview was conducted with the DON on 11/13/14 at 1:02 p.m., regarding how nursing staff was trained in the care and special needs of dialysis residents, and what type of assessment data was to be gathered about a resident's condition on a daily or per shift basis, as referenced in the facility policy. He indicated, "I have no record of any training on ESRD. I looked back to April, 2014. That is obviously not in accordance with our facility's policy." Regarding how he ensured dialysis assessments were done daily, he indicated, "I would assume the policy is referencing assessing the site daily and taking vitals. I have no way to ensure nursing is doing it daily." 3.1-37(a)			
F000312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
	activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview, and record review, the facility failed to ensure showers were given to a resident according to facility policy and resident preferences for 1 of 3 residents reviewed for Activities of Daily Living. (Resident #8) Findings include: Resident #8's record was reviewed on 11/7/14 at 1:12 p.m. The resident's diagnoses included, but were not limited to, depression with anxiety, seizures, restless leg syndrome, diabetes, bipolar disorder, mild MR. On 11/10/14 at 9:49 a.m., during an observation, Resident #8 was lying in his bed watching television. He was alert, pleasant, and in no distress. An 8/8/14 MDS assessment indicated Resident #8 had a BIMS score of 12, which indicated the resident did not have a severe cognitive impairment. On 11/12/14 at 11:19 a.m., during an interview, Resident #8 indicated he wanted to have a shower three times a week. He indicated a preference to have	F000312	An interview was conducted with Resident #8 to determine his shower preference; the care plan was updated to reflect the resident's preference. Interviews will be conducted with all alert residents to ensure that their personal preferences for bathing are met; each interviewed resident's bathing care plan will be reviewed to ensure accuracy and updated as needed. Nursing staff, both licensed nurses and certified nursing assistants will be in serviced on shower/bathing documentation. During care plan meetings the resident's shower/bathing care plan will be reviewed to ensure preferences are being met. The DON or designee will do audits three times per week to ensure the residents are receiving bathing care as care planned for 6 months. The audits will be reviewed during the QA meeting, and the QA committee will determine if there is a need for continued monitoring. Attachment A.	12/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the showers on Monday, Wednesday, and Saturday each week. He indicated he has not received a shower in "it seems like a month." He also indicated "they usually just give me a bed bath." On 11/12/14 at 1:14 p.m., LPN #5 indicated Resident #8 should have received showers twice weekly according to the resident's preference. She indicated Resident #8's assigned shower days were Wednesday and Saturday, and the evening shift provided shower care on those assigned days. She indicated the facility could not provide written evidence that Resident #8 had received showers on the following days: 9/13/14, 9/17/14, 9/20/14, 9/24/14, 10/4/14, 10/8/14, 10/11/14, 10/15/14, 10/22/14, 10/25/14, 11/1/14, and 11/8/14. On 11/12/14 at 1:41 p.m., during an interview, the DON indicated all residents should receive the number of showers per week they desire and as identified by a "preference sheet" which is normally completed for every resident. He indicated CNA's would complete a shower sheet with each shower or bed bath provided to residents in order for CNA's to communicate any new skin conditions to the licensed nursing staff. He also indicated if a shower is refused by a resident, the CNA should complete a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
	shower sheet and indicate the resident refused the shower. A care plan for ADL's (activities of daily living), dated 4/8/14, indicated Resident #8 required "...1 staff participation with bathing..." A facility document, titled "Ancillary Services" and dated 10/27/14, indicated "...The facility does offer 2 showers per week, but if you would like more than 2, the staff will be more than happy to accommodate you..." The document indicated Resident #8 wanted a shower twice a week to be given in the evenings. A facility policy, dated March 2010 and titled "Shower/Tub Bath" indicated "...Notify the supervisor if the resident refuses the shower/tub bath..." 3.1-38(a)(3)(A)(B)(C)(D)(E)			
F000325 SS=D	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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a nutritional problem. Based on observation, interview, and record review, the facility failed to provide a dialysis resident extra protein with his lunch, as ordered, and to follow up on a Registered Dietician recommendation for a Resident with a history of significant weight loss for 2 of 2 residents reviewed for nutrition (Resident #1 & #7) Findings include: 1) The clinical record for Resident #7 was reviewed on 11/13/14, at 10:00 a.m. The diagnoses for Resident #7 included, but were not limited to, end stage renal disease (ESRD). The November, 2014 Physician's Orders for Resident #7 indicated a liberal renal diet with cottage cheese at lunch and dinner. An observation of lunch was made on 11/13/14, at 1:18 p.m. No cottage cheese was observed at Resident #7's meal. An interview was conducted with Cook #4 on 11/13/14, at 1:18 p.m. She reviewed his meal ticket, which did not indicate cottage cheese. She stated, " He isn't one who gets cottage cheese with meals."	F000325	Resident #7's dietary meal tickets has been updated to include cottage cheese for lunch and dinner. Resident #1's Physician was notified of the recommendation for Remeron, no new orders were obtained. An audit was conducted of all residents' dietary meal tickets to ensure they accurately reflect the physician ordered diet. A communication form was developed to communicate and review dietary recommendations, and to ensure follow up. In service was provided regarding the implementation of the communication form. During care plan meetings dietary meal tickets will be reviewed to ensure they accurately reflect the physician order diet. A Change of Condition form has been initiated as an audit tool. All new orders will be reviewed during Daily QA meeting. Dietary recommendations will be reviewed weekly during the Nutritional Assessment Risk meeting. The Change of Condition form will be reviewed daily on scheduled days of work, during Daily QA meeting. This will be an on-going process to ensure compliance.	12/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	An interview was conducted with the DON (Director of Nursing) on 11/13/14, at 1:22 p.m. He indicated, "He's supposed to be getting the cottage cheese as an additional protein because he's on dialysis." 2) The clinical record for Resident #1 was reviewed on 11/10/14 at 10:15 a.m. The diagnoses for Resident #1 included, but were not limited to, bipolar, schizophrenia, and peptic ulcer disease. A review of Resident #1's weights were as follows: 7/8/14=144.6 8/8/14=143.1 9/8/14=133.6 9/15/14=132.2 9/22/14=133.6 9/29/14=133.4 10/06/14=133.6 A Nutrition Progress Note, dated 9/13/14, indicated, "Nutrition note-wt [weight]: 135.6 # [pounds], indicates [symbol for down] 7.5 [symbol for pounds]...sign [significant] wt [weight] loss....may consider weekly weights [symbol for times] 4 weeks...." A Nutrition Progress Note, dated 9/26/14, indicated, "...pt [patient] shows sign wt			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
	loss [symbol for times] 30 days....noted [symbol for decrease] to intakes recently....Addendum: consider use of remeron [medication for appetite stimulant].... " No other mention of Remeron as an appetite stimulant for Resident #1 was noted in clinical record. During an interview with Director of Nursing (DON), on 11/12/14 at 11:31 a.m., the DON indicated the Registered Dietician (RD) was supposed to give her recommendations to the Dietary Manager. A follow up regarding a consideration for Remeron as appetite stimulant for Resident #1 was requested at this time. On 11/12/14 at 11:53 a.m., the DON indicated he was unable to locate any follow up related to the RD recommendation for Remeron. The DON further indicated he was unsure of the process for relaying RD recommendations to the facility/IDT (Inter-Disciplinary Team) during the time of the recommendation, since he was not in the DON position at that time. The DON also indicated the RD recommendation was probably overlooked due to the change in management/ownership at the facility			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
	around the time of the recommendation. 3.1-46(a)(1) 3.1-46(a)(2)			
F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. 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. Based on observation, interview, and record review, the facility failed to monitor for side effects and behaviors related to psychotropic medication use for 2 of 5 residents reviewed for unnecessary medication use. (Resident #'s 9, 11)	F000329	The MAR for Resident #9 and Resident #11 has been updated to include the monitoring for adverse effects of psychotropic medications. An audit will be conducted of residents receiving psychotropic medications; all residents receiving psychotropic medications will have monitoring included on their December 2014	12/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
	1) Resident #11's record was reviewed on 11/7/14 at 11:18 a.m. The resident's diagnoses included, but were not limited to, depression, anxiety, COPD (chronic obstructive pulmonary disease), DM (diabetes mellitus) type II, CAD (coronary artery disease), HTN (hypertension), CHF (congestive heart failure). The resident's medications included, but were not limited to, klonopin, lasix, cymbalta, trazodone, and oxycodone. A 10/17/14 MDS assessment indicated Resident #11 had a BIMS score of "15" which indicated she had no significant cognitive impairment. The assessment also indicated the resident had a diagnosis of depression, among other diagnoses, and it indicated the resident took antidepressant medication. On 11/10/14 at 12:18 p.m., Resident #11 was observed being escorted in a hallway by a staff member. The resident was alert, pleasant, and in no distress. On 11/10/14 at 2:06 p.m., during an interview, Resident #11 indicated being satisfied with her medication regimen as ordered by the physician. She indicated having no concerns with pain control or with medication side effects. She also indicated not feeling overly sedate or		MAR, and each month thereafter. Attachment C. An in service will be conducted regarding signs / symptoms of adverse effects related to psychotropic medications and documentation on the MAR. A Change of Condition form has been implemented to include Psychotropic medication monitoring. The DON or designee will randomly audit the MAR records three times weekly for 6 months, to ensure monitoring is occurring for residents receiving psychotropic medications. The audits will be reviewed during the QA meeting, and the QA committee will determine if there is a need for continued monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
	unusual on her current medications. On 11/12/14 at 10:55 a.m., Resident #11 was watching television in a wheelchair in her room. She was alert, pleasant, and in no distress. All care planned interventions were in place. On 11/13/14 at 9:39 a.m., during an interview, the SSD indicated Resident #11 is receiving Klonopin for anxiety related to COPD, cymbalta for depression and pain, trazodone for insomnia. She also indicated Trazodone was started on 4/14/14. She indicated Klonopin was started 4/28/14. She indicated resident #11 has not had any behavioral incidents or reports of behaviors for the resident since 5/28/13. On 11/13/14 at 11:54 p.m., during an interview, the Psychiatrist indicated he was not aware of any side effects or adverse behaviors for which Cymbalta was being used. He also indicated the use of Cymbalta was for neuropathic pain. He indicated there were lower doses available for Cymbalta, other than 120mg daily, but none of the lower doses had been attempted for Resident #11. On 11/13/14 at 2:37 p.m., during an interview, the DON (Director of Nursing) indicated facility requires a daily			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
	monitoring and documentation of any psychotropic medication side effects or adverse behaviors. He indicated the facility could not provide such daily documentation for Resident #11 prior to 11/11/14. A care plan for psychotropic medication use, dated 4/10/14, indicated "...AIMS to be completed quarterly..." Other interventions, from a 10/17/14 antidepressant medication care plan, indicated staff should monitor for medication side effects and adverse effects of psychotropic medication use. A psychiatric progress note, dated 11/3/14, indicated Resident #11 was being evaluated for a GDR of "...Klonopin..." The progress note indicated "...No behavior or mood issues noted in recent charting or reported from staff..." The progress note did not indicate a diagnosis of depression for Resident #11. The note indicated a "Depression Score" of "0/27" for Resident #11 which indicated the resident did not have depression. A facility policy, dated February 2013 and titled "Antipsychotic Medication Use", indicated "...Monitoring for side effects will be documented daily on the medication administration records			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
	(MAR)..." Medication administration records for the months of February, March, April, May, June, July, August, September, and October of 2014 did not include an order for nursing staff to monitor for side effects for side effects of psychotropic medication use. 2) The clinical record for Resident #9 was reviewed on 11/7/14, at 10:00 a.m. The diagnoses for Resident #9 included, but were not limited to, bipolar disorder. The November, 2014 Physician's Orders for Resident #9 indicated he received the following antipsychotic medications: Seroquel 50 mg at 8 a.m. effective 9/17/14 and Seroquel 125 mg at 6 p.m. effective 9/17/14. The September, October, and November, 2014 MAR (medication administration record) did not indicate monitoring for signs/symptoms of adverse reactions to psychotropic medication until 11/11/14. An 11/11/14 Telephone Order indicated, "Monitor for s/s of adverse reaction of psychotropic medication q (every) shift." An interview was conducted with the SSD (Social Services Director) on 11/12/14, at 2:08 p.m., regarding how the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	facility was monitoring for adverse side effects of psychotropic medications prior to 11/11/14. She indicated, "They have it listed on the MAR every month. It was added back on the MAR yesterday. It was dropped off the MAR when he came back in September (2014), They would be doing it in the nurses notes, and it should have been on the MAR when he came back in September. An interview was conducted with the SSD on 11/13/14, at 10:20 a.m., regarding verification of monitoring for adverse side effects in the nurses notes. She indicated, "I did not find verification we've been monitoring (prior to 11/11/14) for adverse reactions to psychotropic meds (medications). We should have been." The Administrator provided the Antipsychotic Medication Use policy on 11/13/14, at 10:00 a.m. It indicated, "Monitoring for side effects will be documented daily on the medication administration records (MAR). " 3.1-48(a)(3)			
F000428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
	licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.			
	Based on observation, interview, and record review, the facility failed to act on pharmacy recommendations for 1 of 5 residents reviewed for unnecessary medications. (Resident #9) Findings include: 1. The clinical record for Resident #9 was reviewed on 11/7/14, at 10:00 a.m. The diagnoses for Resident #9 included, but were not limited to, bipolar disorder. The 10/24/14 Note To Attending Physician/Prescriber from the pharmacy indicated, "(Name of Resident #9) is receiving Seroquel, Levothyroxine and Cyanocobalamin. Please consider checking a fasting lipid panel and B12 yearly and a TSH every 6 months." The Physician/Prescriber Response section of the note was not completed. There was no information in the clinical record to indicate the physician responded to this pharmacy recommendation. The 11/4/14 Note To Attending Physician/Prescriber from the pharmacy indicated, "Name of Resident #9) is	F000428	Resident #9's Physician was notified regarding the Pharmacy Recommendation…. All November Pharmacy Recommendations will be reviewed to ensure Physician response. An in-service was provided to the DON by the Director of Clinical Operations, regarding policy for Pharmacy Recommendations and follow up or response from the Physician. The Administrator or designee will review the Pharmacy Recommendations monthly for appropriate notification of Physician and Physician response for 6 months. The audits will be reviewed during the QA meeting, and the QA committee will determine if there is a need for continued monitoring.	12/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
	receiving vitamin B12 1000 mg monthly. The last Hgb was 14.9 mg/dl. Please consider discontinuing the vitamin B 12. If continued therapy is needed, please consider checking a vitamin B 12 level annually. The Physician/Prescriber Response section of the note was not completed. There was no information in the clinical record to indicate the physician responded to this pharmacy recommendation. An interview was conducted with the SSD (Social Services Director) on 11/13/14, at 10:20 a.m. She indicated, "We don't have a response for the October and November, 2014 pharmacy recommendations. Normally, the M.D. responds in the response section. We put the recommendations in her book, and she checks them weekly. I don't know why there's no response for these. Before the response (from the physician), the recommendations go in the doctor book. After the response (from the physician), they go in the consult section of the chart." An interview was conducted with the DON on 11/13/14, at 10:36 a.m., regarding lack of responses to the 10/24/14 and 11/4/14 pharmacy recommendations. He indicated, "I don't know why she hasn't responded to either			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
	recommendation. She comes here at least weekly. She was last here on 11/6/14. We don't have a system in place to ensure the doctor is responding to pharmacy recommendations. The pharmacy emails all recommendations, about monthly. I print them off, then put them in the physician books. I process the recommendations after the doctor responds, but there's no process to check and see if the doctor has responded. (Name of Nurse Practitioner) is the nurse practitioner. She was here on 11/6/14." NP #10 was observed in the building on 11/7/14. The DON provided a list of dates Resident #9's physician/prescriber was in the building. The list included dates of 11/5/14 and 10/27/14. 3.1-25(i)			
F000431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
	must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation, interview, and record review, the facility failed to properly dispose of expired inhalers in 2 of 2 medication carts reviewed for medication storage. This affected 2 of 4 residents that received inhalers from the West Side Medication Cart and 2 of 3 residents that received inhalers from the East Side Medication Cart (Resident #'s 8, 9, 14, & 31) Findings include: 1. During a random observation of the East Side Medication Cart, on 11/13/14	F000431	The expired inhalers for Residents #8, Resident #14, Resident #9, and Resident #31 were properly disposed of, per facility policy. An audit was conducted for both (2 of 2) facility medication carts, no other expired medication were identified. An in service will be provided to the licensed nursing personnel regarding the storage and disposal of medications. The facility policy was reviewed, an audit of medication carts will be conducted on the 10:30p-6:30a shift. The DON or designee will review the audit sheet weekly for 6 months. The audits will be reviewed during the QA meeting,	12/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	at 10:02 a.m. with LPN #1, two Advair inhalers were observed to be expired. An Advair 250/50 inhaler for Resident #8 had a 10/9/14 open date written on the medication. An Advair 250/50 inhaler for Resident #14 had a 9/30/14 open date written on the medication. During an interview with LPN #1, on 11/13/14 at 10:05 a.m., LPN #1 indicated she was unsure of when Advair expired. LPN #1 further indicated Resident #8 was administered the Advair that morning (11/13/14) and LPN #1 also indicated Resident #14 refused her Advair that morning, but the medication was ordered for daily use. The November MAR (Medication Administration Record) indicated Resident #14 received Advair 250/50 on 11/12/14 at 8 p.m. 2. During a random observation of the West Side Medication Cart, on 11/13/14 at 10:15 a.m., with LPN #2, two expired Advair inhalers were observed. An Advair 250/50 inhaler for Resident #9 had a 9/11/14 open date written on the medication. An Advair 250/50 inhaler for Resident #31 had a 9/18/14 open date written on the medication. During an interview with LPN #2, on		and the QA committee will determine if there is a need for continued monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
	11/13/14 at 10:17 a.m., LPN #2 indicated she was unsure when Advair expired but she thought it was a month after opening. The November MAR for Resident #9 indicated Advair 250/50 was administered that morning (11/13/14) and the November MAR for Resident #31 indicated Advair 250/50 was administered on 11/12/14 at 8 p.m. During an interview with Director of Nursing (DON), on 11/13/14 at 11:20 a.m., he indicated Advair expired a month after opening. A policy titled, [Name of Pharmacy] LTC Expiration Dating Policy, no date, was received from the Director of Nursing on 11/13/14 at 12:02 p.m. The policy indicated Advair expires 30 days following removal from the foil pouch. 3.1-25(o)			
F000463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation and interview, the facility failed to ensure a resident's bedside call light was working properly for 1 of 30 resident's bedside call lights	F000463	Resident #19's call light worked during the Environmental tour with survey team member, and has been tested several times with no issues noted. An audit	12/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
	reviewed. (Resident #19) Findings include: During a random observation, on 11/6/14 at 11:58 p.m., Resident #19's bedside call light was pushed multiple different times and the call light did not sound, nor light up. On 11/10/14 at 11:57 a.m., Resident #19's bedside call light was observed under his bed, where the call light cord was tangled and the call light button attached tightly to the bedframe. The call light button was pulled away from the bedframe and was pushed several times. The call light did not sound, not light up during this time. During an environmental tour with the Maintenance Director, on 11/12/14 at 2:45 p.m., Resident #19's bedside call light was lightly pushed and the call light immediately turned on and sounded. During an interview with the Maintenance Director, on 11/12/14 at 2:50 p.m., he indicated he was unsure if he recently fixed the bedside call light for Resident #19, because he was constantly fixing call lights in the facility. The Maintenance Director also indicated the call light system consistently had		was conducted of all resident call lights, including restroom call lights, any issues noted were immediately corrected by the facility Maintenance Director. The Maintenance Director will continue monthly preventative maintenance audits of the call system, for both the resident rooms and resident bathrooms, including shower room. Any issues noted will be corrected immediately. Attachment H. The Preventative Maintenance audits will be reviewed during the QA committee meetings. This will be an on-going process to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
	problems with wiring and lighting, since he started in his position. The Maintenance Director further indicated the facility recently put in a "bid" for a new call light system. 3.1-19(u)(1)			
F000505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. Based on interview and record review, the facility failed to promptly notify a Physician of out of range blood glucose results for 1 of 5 residents reviewed for lab notification. (Resident #4) Findings include: The clinical record for Resident #4 was reviewed on 11/12/14 at 10:15 a.m. The diagnoses for Resident #4 included, but were not limited to, diabetes mellitus, schizophrenia, and dementia. A Physician's Order, dated 10/2/14, indicated to provide blood glucose testing twice a day and to call the Physician's office if the result was less than 70 or greater than 250. A Blood Glucose Testing Log indicated the following blood glucose results:	F000505	Resident #4's Physician was notified of the previous controlled blood glucose results, no new orders were obtained. Resident #4 suffered no adverse effects from the lack of reporting of blood glucose testing. An audit will be conducted of all residents with orders for controlled blood glucose testing; no other residents were identified to be affected by this deficient practice. An in service will be provided to licensed nurses regarding diabetic protocol, including notification of physician. The DON or designee will conduct audits three times weekly for 6 months of the controlled blood glucose results. The audits will be reviewed during the QA meeting, and the QA committee will determine if there is a need for continued monitoring.	12/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	10/10/14 at 5:00 p.m.=323, 10/14/14 at 5:00 p.m.=291, 10/15/14 at 5:00 p.m.=312, 10/16/14 at 5:00 p.m.=314, 10/17/14 at 5:00 p.m.=254, 10/20/14 at 5:00 p.m.=267, & 10/22/14 at 5:00 p.m.=283. Physician notification, of the above blood glucose results, was not located in the clinical record. During an interview with the Director of Nursing (DON), on 11/12/14 at 10:55 a.m., he indicated Physician notification should be documented on the Blood Glucose Testing Log or in the Nurse's Notes. The DON indicated he will look for Physician notification for the above dates. On 11/12/14, at 11:31 a.m., the DON indicated he was unable locate any Physician notification of the above blood glucose results. 3.1-35(g)(2)			
F000514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented;			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
	readily accessible; and systematically organized. 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. Based on interview and record review, the facility failed to ensure accurate documentation, regarding lab orders for a resident receiving anticoagulant medication and a diagnosis on physician orders, for 2 of 5 residents reviewed for unnecessary medication. (Residents #5 and #11) Findings include: 1) The clinical record for Resident #5 was reviewed on 11/13/14, at 1:00 p.m. The diagnoses for Resident #5 included, but were not limited to, atrial fibrillation. The September, October, and November, 2014 Physician's Orders indicated Warfarin (anticoagulant medication) daily...3 mg on Tuesday, Thursday, Saturday, and Sunday, 4 mg on Monday, Wednesday, and Friday effective 9/9/14. There were no orders for routine PT/INR labs included in the September, October, and November, 2014 Physician's Orders. The laboratory section of Resident #5's	F000514	Resident #5's Physician was notified and orders were obtained for routine PT/INR. The Physician orders for Resident #11 were clarified to reflect an accurate diagnosis for the medication. An audit was conducted of all residents receiving anti-coagulation therapy, one other resident was identified, no issues noted. An audit will be conducted of physician orders to ensure accurate diagnoses are reflected for each physician prescribed medication. Attachment C. An in service will be conducted for licensed nurses regarding physician orders, diagnosis and proper timely physician notification. The Change of Condition form will be implemented, which will include review of all new orders, additionally all new orders will be reviewed during Daily QA meeting. This will be an on-going process to ensure compliance.	12/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
	clinical record indicated PT/INR labs were taken on 10/16/14 and 9/11/14. An interview was conducted with the DON (Director of Nursing) on 11/13/14, at 2:29 p.m., regarding an order for PT/INR labs. He stated, "I'm not finding one. I don't know why there is no order. There should be an order because he's on coumadin (name brand warfarin)." An interview was conducted with the DON on 11/14/14, at 9:50 a.m. He indicated, "We called the doctor last night, (name of Physician #11). He's been on monthlies. She's comfortable with monthlies. He's stable, and does not fluctuate. She's going to keep him on monthlies. There was a standing order from February (2014), from his previous admission." An interview was conducted with Physician #11 on 11/14/14, at 10:20 a.m. She indicated, "He has an order. I gave it yesterday. It was every month before his hospitalization. Now, it's going to be every 2 weeks and today." The 11/14/14 Physician Telephone Order indicated, "Clarification of order PT/INR Today, then q (every) 2 weeks." 2) Resident #11's record was reviewed on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/14/2014
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140	

(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
	11/7/14 at 11:18 a.m. The resident's diagnoses included, but were not limited to, depression and neuropathic pain. Physician's orders for November of 2014 included an order for Cymbalta for a "..Dx: (diagnosis) Depression..." On 11/13/14 at 1:11 p.m., during an interview, the MDS coordinator indicated Resident does not have a diagnosis of depression. An email from a pharmacy consultant, undated, indicated Resident #11 "...has been receiving Cymbalta 120mg QD (daily) for neuropathic pain..." and the email indicated the Cymbalta was "...not being used for a psychiatric condition..." A psychiatric progress note, dated 11/3/14, did not indicate a diagnosis of depression for Resident #11. The note indicated a "Depression Score" of "0/27" for Resident #11, which indicated the resident did not have depression. On 11/13/14 at 11:54 p.m., during an interview, Resident #11's Psychiatrist indicated the use of Cymbalta was for neuropathic pain, not depression. 3.1-50(a)(2)			