

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 09/05/2013	
NAME OF PROVIDER OR SUPPLIER SUGAR GROVE RETIREMENT COMMUNITY LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 5865 SUGAR LN PLAINFIELD, IN 46168			
(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			
R000000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey Dates: September 3, 4, and 5, 2013.</p> <p>Facility Number: 012394</p> <p>Survey Team: Shannon Pietraszewski, RN-TC Jeanna King, RN</p> <p>Census bed type: Residential: 121 Total: 121</p> <p>Census Payor type: Residential: 121 Total: 121</p> <p>Sample: 8 Supplemental Sample: 2</p> <p>These state findings are cited in accordance with 410 IAC 16.2</p> <p>Quality review completed 09/13/2013 by Brenda Marshall Nunan, RN.</p>	R000000	The Plan of Correction is neither an agreement with nor an admission of wrong doing by this facility or its staff members. Rather, it is submitted for compliance purposes. This facility alleges substantial compliance with this plan of correction as of September 27, 2013 and requests paper compliance for this survey.				

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/05/2013	
NAME OF PROVIDER OR SUPPLIER SUGAR GROVE RETIREMENT COMMUNITY LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 5865 SUGAR LN PLAINFIELD, IN 46168			
(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			
R000036	<p>410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.</p> <p>Based on record review and interview, the facility failed to notify a physician, dietician and family member of a change in condition related to a significant weight loss for 1 of 8 residents reviewed for decline in resident's health. (Resident #5)</p> <p>Findings include:</p> <p>1. Resident #5's record was reviewed on 9/3/13 at 2:30 p.m. Resident #5's diagnoses included, but were not limited to, dementia and diabetes. The resident was admitted to the facility on April 3, 2013.</p> <p>The resident's monthly weight record indicated the following:</p> <p>April 2013: 168 pounds May 2013: 163 pounds June 2013: 160 pounds July 2013: 163 pounds</p>	R000036	Resident #5 discharged from the facility prior to the opportunity to apply corrective action. A review of weights for 100% of all residents was performed. The physicians and powers of attorney for all residents with a 5% or greater loss of weight were notified by September 27, 2013, and these residents were referred to the Registered Dietician for further review during the monthly visit in October. As staff are obtaining monthly weights, all residents with a 5% or greater change in weight from the previous month or over the past three months will be referred to the registered dietitian for review. The physicians and powers of attorney for residents meeting this criteria will also be notified. The Director of Health Services or her representative will audit 100% of weights for one month, 50% of weights for the following month and 25% of weights for four additional months to ensure compliance with notifications and	09/27/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/05/2013	
NAME OF PROVIDER OR SUPPLIER SUGAR GROVE RETIREMENT COMMUNITY LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 5865 SUGAR LN PLAINFIELD, IN 46168			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>August 2013: 160 pounds September 2013: 155 pounds</p> <p>The resident was weighed again on 9/3/13 at 2:50 p.m. The resident's weight was 150 pounds.</p> <p>The last RD (Registered Dietician) note was dated 4/4/13. The assessment indicated the resident was on a regular diet.</p> <p>There was no documentation to indicate if the physician, dietician or a family member were notified of the resident's weight loss.</p> <p>An interview with LPN #3 on 9/3/13 at 3:20 p.m., indicated she was unsure if the physician, dietary, or the family had been informed of the weight loss.</p> <p>An interview with the General Manager (Administrator) on 9/5/13 at 5:00 p.m., indicated the facility did have a Registered Dietician to address the resident's weight loss.</p>		referrals for residents with a 5% or greater change in weight from the previous month or over the previous three months. This change will be effective September 27, 2013.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUGAR GROVE RETIREMENT COMMUNITY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 5865 SUGAR LN PLAINFIELD, IN 46168
--	--

(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
--------------------	--	---------------	---	----------------------

R000117	<p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure at least one staff member with a current first aid certificate and/or CPR (cardiopulmonary resuscitation) certificate was scheduled during the night shift for 3 out of 3 shifts reviewed. (September 1 to Sept 4, 2013).</p> <p>Findings include:</p>	R000117	<p>At the time of the survey, no residents were identified as affected by the deficiency. No residents required CPR or First Aid Services from non-certified staff members. 100% of existing nurses were certified in First Aid and CPR prior to September 27, 2013 or their first shift thereafter. 100% of nursing staff hired will be required to provide evidence of current First Aid and CPR certification prior to orientation. The Business Office Manager or</p>	09/27/2013
---------	--	---------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 09/05/2013	
NAME OF PROVIDER OR SUPPLIER SUGAR GROVE RETIREMENT COMMUNITY LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 5865 SUGAR LN PLAINFIELD, IN 46168			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>A schedule for the week of September 1-7, 2013 was reviewed on 9/4/13 at 2:50 p.m. The schedule indicated there were no staff members who were first aid and/or CPR certified on the 10:00 p.m. to 6:00 a.m. shift for dates of 9/1/13, 9/2/13 and 9/3/13.</p> <p>An interview with Resident Director and General Manager (Administrator) on 9/4/13 at 3:50 p.m., indicated no first aid and/or CPR certified staff was scheduled on the above dates.</p>		<p>her designee will monitor all CPR and First Aid certifications monthly for expirations, prompting the employee and Director of Health Services for renewals. The General Manager will audit 100% of nursing staff monthly for current First Aid and CPR certification for six months. This change will be effective September 27, 2013.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/05/2013	
NAME OF PROVIDER OR SUPPLIER SUGAR GROVE RETIREMENT COMMUNITY LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 5865 SUGAR LN PLAINFIELD, IN 46168			
(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			
R000120	<p>410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows:</p> <p>(1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel.</p> <p>(2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia.</p> <p>(3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.</p> <p>Based on record review and interview, the facility failed to ensure facility staff received six hours of</p>	R000120	At the time of the survey, no residents were identified as affected by the non-compliance.	09/27/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/05/2013
NAME OF PROVIDER OR SUPPLIER SUGAR GROVE RETIREMENT COMMUNITY LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5865 SUGAR LN PLAINFIELD, IN 46168		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>dementia specific training within 6 months of hire for 6 out of 10 employees who had been employed at the facility for more than six months and provided services to residents with a diagnosis of dementia, including residents residing in a locked unit. (CNA #4, CNA #5, LPN #6, LPN #7, CNA #8 and CNA #9)</p> <p>Findings include:</p> <p>Employee records were reviewed on 9/4/13 at 2:00 p.m. There was a lack of documentation in the facility's dementia training inservices to indicate 6 of the 10 employees had received the initial 6 hours of dementia training within 6 months of employment.</p> <p>An interview with the General Manager (Administrator) on 9/4/13 at 3:30 p.m., acknowledged the dementia training was not completed.</p>		<p>Following the survey, no residents were identified as affected by the non-compliance. 100% of existing staff who works in the memory care unit and whose tenure exceeds six months completed the six hours of mandatory dementia training prior to September 27, 2013. Staff members who had not yet reached six months of tenure were educated as to the need to complete the required dementia training. All staff members hired on or after September 27, 2013. The Business Office Manager or her designee will monitor all employee dementia training monthly for completion of required training within the six month period, prompting the employee and employee's supervisor for completion as needed. The General Manager will audit 100% of staff monthly for timely completion of required dementia training for six months. This change will be effective September 27, 2013.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUGAR GROVE RETIREMENT COMMUNITY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 5865 SUGAR LN PLAINFIELD, IN 46168
--	--

(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
R000121	<p>410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.</p> <p>(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/05/2013	
NAME OF PROVIDER OR SUPPLIER SUGAR GROVE RETIREMENT COMMUNITY LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 5865 SUGAR LN PLAINFIELD, IN 46168			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Based on observation and interview, the facility failed to ensure an employee received a second step PPD (Tuberculosis test) within three weeks after the first step for 1 out of 11 employees reviewed for employee health screens. (CNA #9)</p> <p>Findings include:</p> <p>Employee health records were reviewed on 9/4/13 at 12:00 to 12:30 p.m. CNA #9's health record indicated she had a first step PPD (Tuberculosis test) on 7/18/13. The record lacked documentation to indicate a 2nd step PPD has been completed.</p> <p>An interview with General Manager (Administrator) on 9/4/13 at 3:50 p.m., indicated she thought the employee had a PPD test with her previous employer but was unable to obtain the record. The General Manager indicated she would have the CNA repeat the series of PPD tests.</p>	R000121	At the time of the survey, no residents were identified as affected by the deficiency. No residents demonstrated signs or symptoms of exposure to tuberculosis from exposure to the employee in question. 100% of all employee files were reviewed for compliance with mandatory TB testing, and TB testing was completed for the employee not in compliance prior to their next shift. The Business Office Manager or her designee will monitor all employee TB tests for completion of mandatory testing requirements with each new hire and monthly for annual TB tests, prompting the employee, supervisor and Director of Health Services for compliance as required. The General Manager will audit 100% of employee files monthly for compliance with TB testing for six months. This change will be effective September 27, 2013.	09/27/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/05/2013	
NAME OF PROVIDER OR SUPPLIER SUGAR GROVE RETIREMENT COMMUNITY LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 5865 SUGAR LN PLAINFIELD, IN 46168			
(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			
R000217	<p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on observation, record review and interview, the facility failed to ensure the service plans were updated in frequency and need in relation to oxygen therapy, hospice, home health and laboratory services for residents who reside on the Dementia Unit for 5 of 8 residents</p>	R000217	The identified residents' health services plans were updated to address all oxygen therapy, hospice, home health or recurrent laboratory services currently provided to these residents. 100% of all health service plans for residents with oxygen therapy, hospice, home health or recurrent laboratory services were reviewed	09/27/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/05/2013	
NAME OF PROVIDER OR SUPPLIER SUGAR GROVE RETIREMENT COMMUNITY LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 5865 SUGAR LN PLAINFIELD, IN 46168			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>reviewed for service plans. (Resident #1, #2, #3, #4 and #5)</p> <p>Findings include:</p> <p>1. Resident #2's record was reviewed on 9/3/13 at 9:45 a.m. Resident #2's diagnoses included, but were not limited to, hypertension, diabetes, and DVT (deep vein thrombosis).</p> <p>A physician's order dated 3/7/13, indicated to hold Coumadin (blood thinner) for 3 days then start 6 milligrams (mg) every day and weekly PT/INR (a diagnostic lab for blood thinners). There was lack of documentation indicating the PT/INR's were done the week of 3/28/13, 4/4/13, 4/11/13, 4/25/13, 5/2/13, 5/9/13, 5/23/13, 5/30/13, 6/6/13, 6/20/13, 6/27/13, 7/4/13, 7/11/13, 7/18/13, 7/25/13, 8/1/13, 8/8/13, 8/22/13 and 8/29/13.</p> <p>A physician order dated 8/12/13, indicated for the resident was to have a therapy evaluation and treatment for osteoarthritis to his left leg. An interview with LPN #1 during this time, indicated the resident was receiving home health services for management of his lower extremities in regards to edema and wound care.</p>		<p>to ensure current services were included on the health services plan. Health Services Plans were updated as necessary. Nursing will be educated on the Health Services Plan, the need for inclusion of oxygen therapy, hospice, home health or recurrent laboratory services on the health services plan as well as notification of the Director of Health Services of the initiation or conclusion of such services. The Director of Health Services or her designee will monitor utilization of ancillary services for all residents on an Ancillary Services spreadsheet monthly. The Director of Health Services or her designee will audit ten health services plans per week for four weeks followed by ten health services plans per month for three additional months to ensure compliance. This change will be effective September 27, 2013.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 09/05/2013	
NAME OF PROVIDER OR SUPPLIER SUGAR GROVE RETIREMENT COMMUNITY LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 5865 SUGAR LN PLAINFIELD, IN 46168			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Review of the resident's service plan updated 4/16/13, did not indicate the resident was receiving home health services.</p> <p>An interview with the Resident Director on 9/3/13 at 11:00 a.m., indicated home health services should have been included in the service plan.</p> <p>During an interview on 9/4/13 at 3:20 P.M., the General Manager (Administrator) indicated there was an old standing order dated 12/10/12 for monthly PT/INR. The General Manager indicated the staff did not change the frequency/order on the new monthly Physician Recapitulation orders for the months of April 2013 to September 2013.</p> <p>2. Resident #3's record was reviewed on 9/3/13 at 11:30 a.m. Resident #3's diagnoses included, but were not limited to, hypertension, IDDM (insulin dependent diabetic), CVA (stroke), and left side weakness.</p> <p>A physician's order dated 6/12/13, indicated the resident to have a foley catheter placed.</p> <p>Review of the resident's service plan updated on 6/12/13, did not indicate</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 09/05/2013	
NAME OF PROVIDER OR SUPPLIER SUGAR GROVE RETIREMENT COMMUNITY LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 5865 SUGAR LN PLAINFIELD, IN 46168			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>the resident had a foley catheter.</p> <p>An interview with LPN #1 on 9/3/13 at 11:30 a.m., indicated the resident was receiving home health services for management of the foley catheter. The service plan did not indicate the resident was receiving home health services.</p> <p>An interview with the Resident Director on 9/3/13 at 11:00 a.m., indicated home health services should have been included in the service plan for care of the foley catheter.</p> <p>An undated policy titled, "Resident Service Plan", was provided by the Resident Director on 9/3/13 at 1:30 p.m. The policy indicated the service plan was to be reviewed and revised every six months or following a change in condition.</p> <p>3. Resident #1's oxygen concentrator was observed on 9/4/13 at 9:30 a.m. The concentrator humidification container (container for special water which supplies moisture to the dry air)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUGAR GROVE RETIREMENT COMMUNITY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 5865 SUGAR LN PLAINFIELD, IN 46168
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>was observed to be empty and had a white film inside the container. The resident was observed to have had dried blood around his left nostril.</p> <p>Resident #1's record was reviewed on 9/3/13 at 11:15 a.m. Resident #1's diagnoses included, but were not limited to, exacerbation of congestive obstructive pulmonary disease (lung disease) and congestive heart failure.</p> <p>A physician's order dated 6/10/13, indicated the resident was receiving oxygen therapy.</p> <p>A physician's order dated 7/26/13, indicated the resident was admitted to hospice services.</p> <p>Review of the service plan updated on 7/17/13, did not indicate the resident was receiving oxygen therapy or receiving hospice services.</p> <p>An interview with the Resident Director on 9/3/13 at 11:55 a.m., the Resident Director indicated hospice services should have been included in the service plans.</p> <p>An interview with LPN #2 on 9/3/13 at 12:15 p.m., indicated the service plan should have been updated to include hospice services.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUGAR GROVE RETIREMENT COMMUNITY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 5865 SUGAR LN PLAINFIELD, IN 46168
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>An interview with LPN #2 on 9/4/13 at 10:00 a.m., indicated hospice was responsible for the oxygen concentrator and she would notify them of the humidification need.</p> <p>An interview with the Resident Director on 9/5/13 at 4:30 p.m., indicated the oxygen should have been on the service plan.</p> <p>4. Resident #5's record was reviewed on 9/3/13 at 2:30 p.m. Resident #5's diagnoses included, but were not limited to, dementia and diabetes. The resident was admitted to the facility on April 3, 2013.</p> <p>A physician order dated 4/30/13, indicated HgbA1C (lab for blood sugars) and BMP (basic metabolic panel) every 3 months. There was no BMP's obtained after the physician's order. The last HgbA1C was 4/26/13.</p> <p>Review of the service plan updated on 5/2/13, did not indicate coordination of laboratory services or home health services.</p> <p>A physician order dated 8/6/13, indicated physical and occupational therapy evaluation for the resident.</p> <p>An interview with LPN #3 during this</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUGAR GROVE RETIREMENT COMMUNITY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 5865 SUGAR LN PLAINFIELD, IN 46168
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>time, indicated the resident was receiving home health services for therapy.</p> <p>An interview with the Resident Director on 9/4/13 at 9:00 a.m., indicated the service plan should have been updated to include laboratory services and home health services. The Resident Director indicated the labs had not been obtained.</p> <p>5. Resident #4's record was reviewed on 9/3/13 at 3:00 p.m. Resident #4's diagnoses included, but were not limited to, dementia and congestive heart failure.</p> <p>A physician order dated 7/13/12, indicated for the resident to have quarterly blood draws for CBC (complete blood count), BMP (basic metabolic profile), BNP (blood draw to check on congestive heart failure). There was lack of documentation to indicate the CBC, BMP and the BNP had been obtained between April 2013 and September 2013.</p> <p>An interview with the Resident Director on 9/4/13 at 9:00 a.m., indicated the service plan should have been updated to include laboratory services.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/05/2013	
NAME OF PROVIDER OR SUPPLIER SUGAR GROVE RETIREMENT COMMUNITY LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 5865 SUGAR LN PLAINFIELD, IN 46168			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Resident #4's record was reviewed on 9/3/13 at 3:00 p.m. Resident #4's diagnoses included, but were not limited to, dementia and congestive heart failure.</p> <p>An interview with the Resident Director on 9/4/13 at 9:00 a.m., indicated the labs had not been obtained.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/05/2013	
NAME OF PROVIDER OR SUPPLIER SUGAR GROVE RETIREMENT COMMUNITY LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 5865 SUGAR LN PLAINFIELD, IN 46168			
(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			
R000242	<p>410 IAC 16.2-5-4(e)(2) Health Services - Offense (2) The resident shall be observed for effects of medications. Documentation of any undesirable effects shall be contained in the clinical record. The physician shall be notified immediately if undesirable effects occur, and such notification shall be documented in the clinical record. Based on record review and interview, the facility failed to ensure weekly PT/INR were obtained in relation to a resident receiving coumadin therapy for 1 of 8 residents reviewed for physician orders. (Resident #2)</p> <p>Findings include:</p> <p>Resident #2's record was reviewed on 9/3/13 at 9:45 a.m. Resident #2's diagnoses included, but were not limited to, hypertension, diabetes, and DVT (deep vein thrombosis).</p> <p>A physician's order dated 3/7/13, indicated to hold Coumadin (blood thinner) for 3 days then start 6 milligrams (mg) every day and weekly PT/INR (a diagnostic lab for blood thinners). There was lack of documentation indicating the PT/INR's were done the week of 3/28/13, 4/4/13, 4/11/13, 4/25/13, 5/2/13, 5/9/13, 5/23/13, 5/30/13, 6/6/13, 6/20/13, 6/27/13, 7/4/13,</p>	R000242	The identified resident's physician was notified and the order was clarified to ensure accuracy of laboratory services. The resident did not appear to have suffered any negative outcomes from the offense. 100% of all residents' orders for laboratory services were reviewed. No additional residents were identified to have missing laboratory services. Any resident with reoccurring laboratory services were included on the Physician Orders as well as the Medication Administration Record. A policy and procedure for Laboratory Services was added to the policy and procedure manual. All nursing staff were educated on the policy and procedures as well as the changes to the Medication Administration Record as well as the physician orders. The Director of Health Services or her designee will audit ten resident charts per week for four weeks followed by ten resident charts per month for three additional months to ensure compliance. This change will be effective September 27, 2013.	09/27/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUGAR GROVE RETIREMENT COMMUNITY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 5865 SUGAR LN PLAINFIELD, IN 46168
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>7/11/13, 7/18/13, 7/25/13, 8/1/13, 8/8/13, 8/22/13 and 8/29/13.</p> <p>An interview with the Resident Director on 9/4/13 at 9:00 a.m., indicated she was investigating the concern for the missing weekly PT/INR results.</p> <p>During an interview on 9/4/13 at 3:20 P.M., the General Manager (Administrator) indicated there was an old standing order dated 12/10/12 for monthly PT/INR. She indicated the physician's order dated 3/7/13, was not sent to pharmacy for the order to be updated on the Physician Recapitulation Orders and Medication Administration Record.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/05/2013	
NAME OF PROVIDER OR SUPPLIER SUGAR GROVE RETIREMENT COMMUNITY LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 5865 SUGAR LN PLAINFIELD, IN 46168			
(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			
R000301	<p>410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted.</p> <p>Based on observation, record review and interview, the facility failed to ensure labels were placed on resident medications for 1 of 3 medication carts. (Medication Cart 300 Hall)</p> <p>Findings included:</p> <p>1. Resident #9's eye drops was observed in a black nylon zippered bag on 9/4/13 at 11:20 a.m. in the 300 Hall medication cart. Resident #9 had two eye drops labeled with black marker #1 and #2, the last name of the resident and her room number.</p> <p>An interview with LPN #2 on 9/4/13 at 2:50 p.m., indicated the resident had returned from cataract surgery last month with both bottles in the black</p>	R000301	<p>The identified resident's medication was clarified as per the physician's order and labeled. The medications on the medication carts were audited for 100% of remaining residents. Any incorrectly labeled medications were corrected or destroyed at that time. Nursing staff was educated on the proper labeling of medications. Nursing staff were also instructed as to the new requirement for weekly audits of the medications on the carts to ensure compliance. The Director of Health Services or her designee will audit ten residents' medications per week for four weeks followed by ten residents' medications per month for three additional months to ensure compliance. This change will be effective September 27, 2013.</p>	09/27/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUGAR GROVE RETIREMENT COMMUNITY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 5865 SUGAR LN PLAINFIELD, IN 46168
--	--

(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
--------------------	--	---------------	---	----------------------

	nylon bag. LPN #2 indicated she should have put a label on both bottles of the eye drops.			
--	---	--	--	--