

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 03/07/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION CONVALESCENT CENTER	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
F0000	<p>This visit was for the Investigation of Complaint IN00103748.</p> <p>Complaint IN00103748 - Substantiated. Federal/State deficiencies related to the allegations are cited at F241 and F9999.</p> <p>Survey dates: March 6 and 7, 2012</p> <p>Facility number: 000157 Provider number: 155254 AIM number: 100274720</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type: SNF/NF: 47 Total: 47</p> <p>Census payor type: Medicare: 6 Medicaid: 31 Other: 10 Total: 47</p> <p>Sample: 3 Supplemental sample: 2</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on March 12,</p>	F0000	<p>This plan of correction is to serve as Sugar Creek Rehabilitation Convalescent Center's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Sugar Creek Rehabilitation Convalescent Center or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in the facility, nor does this submission constitute an agreement or admission of the survey allegations. We are in compliance as of March 14, 2012 and are respectfully requesting paper review.</p>	

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/07/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION CONVALESCENT CENTER	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 PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2012 by Bev Faulkner, RN			

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 03/07/2012	
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION CONVALESCENT CENTER				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			
F0241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on interview and record review, the facility failed to ensure the dignity of residents as denoted by staff using their cell phones in resident care areas, visible to residents and family members. This deficient practice was noted by 2 residents and 1 family member during interviews. This deficient practice affected 2 of 2 residents in the supplemental sample who were interviewed regarding staff use of cell phones. (Residents #D, #E, and CNA #1)</p> <p>Findings include:</p> <p>During an interview with Resident #E on 3-6-12 at 3:05 p.m., she indicated she had noticed different CNA's (Certified Nursing Assistants) using their cell phones at different times while on duty. She indicated it had occurred on all shifts, but indicated, "Notice it's worst [sic] on the 2:30 [p.m.] to 10:30 [p.m.] shift." She indicated, "I don't think it's fair to the residents. [I've] noticed call lights not answered when they're on the phone."</p>	F0241	<p>It is the practice of Sugar Creek Rehabilitation Convalescent Center to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. All residents have the potential to be affected by staff who use cell phones in resident care areas. As indicated in the survey report, the facility had a policy in place regarding cell phone use and facility personnel had been appropriately educated on this policy. Staff were re-educated on cell phone usage and the facility's cell phone policy on 3/8/12. The Director of Nursing or her designee will randomly interview 2 interviewable residents weekly for 30 days then monthly for 6 months regarding the attentiveness of staff and any use of cell phones during resident care. Any issues identified will be addressed by the Administrator or her designee. Results of interviews will be discussed during the facility's QA Committee meeting for additional recommendations as necessary.</p>	03/14/2012			

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 03/07/2012	
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION CONVALESCENT CENTER				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			
	<p>In an interview with Resident #D on 3-6-12 at 3:44 p.m., she indicated CNA #1 "Talks on her phone a lot...Has even been on the phone talking while she's taken care of me a time or two." Resident #D indicated CNA #1 works on the day shift.</p> <p>In a confidential interview with a family member, this person indicated, "I've seen some of the staff talking on their cell phones while they're in the building. Don't know how you [would] stop it. Kind of like people talking on their cell phones in cars; no, they shouldn't do it, but they do it anyway."</p> <p>In interview with the Director of Nursing (DON) on 3-6-12 at 5:44 p.m., she indicated, "I've been battling this about using cell phones since I came here." In interview with the DON on 3-7-12 at 9:35 a.m., she indicated, "Any place I've worked, it seems cell phones are a problem...I am planning on making some changes to the cell phone policy."</p> <p>On 3-7-12 at 1:15 p.m., the Administrator provided a copy of a document entitled, "Inservice Sign In Sheet," which indicated an inservice had been conducted on 10-24-11 which included the topic of "Cellphone use" [sic]. This document indicated this inservice was to be attended</p>						

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 03/07/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION CONVALESCENT CENTER	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
	<p>by all staff . CNA #1's signature was present on the document to indicate she did attend this inservice.</p> <p>On 3-7-12 at 9:24 a.m., the Administrator provided a copy of a policy entitled, "Cell Phone Policy." This policy was identified as the current policy in use by the facility. The policy indicated, "Employees are not allowed to use a cell phone at any time while on the clock. Cell phones should be kept in your locker or in your car. The use of cell phones while on the clock could result in disciplinary action."</p> <p>This Federal tag relates to Complaint IN00103748.</p> <p>3.1-3(t)</p>			

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 03/07/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION CONVALESCENT CENTER	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
F9999	<p>3.1-14 PERSONNEL</p> <p>(k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to the following: (1) Residents' rights.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure annual inservice education was conducted on residents' rights for 1 of 1 employee records reviewed for annual residents' rights education. (CNA #1)</p> <p>Findings include:</p> <p>During record review of CNA#1's employee file on 3-7-12 at 12:48 p.m., there was a lack of information regarding documentation of attendance at any Residents' Rights inservice for the past year.</p> <p>In an interview with the Director of Nursing on 3-7-12 at 2:01 p.m., she indicated, "I cannot find any more Residents' Rights or Abuse inservices</p>	F9999	All residents have the potential to be affected by non-documented inservice sessions. Staff were inserviced on residents' rights on 3/8/12. A schedule of required inservices has been developed and implemented. The Administrator or her designee will monitor staff attendance at all inservices for quality assurance purposes. Any staff who do not attend required inservice training must see the Director of Nursing for individual inservice training.	03/14/2012

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 03/07/2012
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION CONVALESCENT CENTER			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	
	<p>[documentation] for [name of CNA #1] other than 2009. None from 2010 or 2011."</p> <p>This Federal tag relates to Complaint IN00103748.</p> <p>3.1-14(k)(1)</p>				