

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 08/20/2013
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NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT	STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140
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F000000	<p>This visit was for the Investigation of Complaint IN00132988 and IN00134006.</p> <p>Complaint IN00132988 -- Substantiated. Federal/State deficiencies related to the allegations are cited at F226 and F9999.</p> <p>Complaint IN00134006 -- Substantiated. Federal/State deficiencies related to the allegations are cited at F243 and F441.</p> <p>Survey dates: August 19 and 20, 2013</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: 46 Residential: 6 Total: 52</p> <p>Census payor type: Medicare: 4 Medicaid: 32 Other: 16 Total: 52</p>	F000000	<p>Ms. Rhoades, Please accept the attached plan of correction for Sugar Creek Rehabilitation and Convalescent Center for complaint survey ID# XYUS11. Feel free to contact me if you have any questions.</p> <p>Sincerely,</p> <p>Stacy Budd RN RDCO IDE management group (765) 419-1016</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.

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	<p>Sample: 3 Supplemental Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on August 26, 2013, by Janelyn Kulik, RN.</p>			

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to ensure implementation of abuse prohibition policies in regard to training of newly hired employees regarding abuse and abuse prohibition for 1 of 5 staff members hired within the last 120 days. (LPN #1)</p> <p>Findings include:</p> <p>During review of the staff personnel records on 8-20-13 at 1:23 p.m., LPN #1's personnel record did not include documentation of inservice education for resident's rights or abuse prohibition education. Her record did not include documentation of receipt of her position-specific job description, nor did it include documentation of a job-specific orientation listing. LPN #1's record indicated her employment date was 5-3-13.</p> <p>In interview with the Administrator on 8-20-13 at 3:15 p.m., he indicated the information provided was all of the</p>	F000226	F226 483.13(c) DEVELOPMENT/IMPLEMENTATION OF ABUSE/NEGLECT, ETC. POLICIES Sugar Creek Rehabilitation and Convalescent Center does ensure that staff receives in service and education on abuse prohibition policies in orientation upon hire. New hire education includes education on Abuse and Abuse Prohibition policies and processes. Company policy entitled "Abuse Prevention" was reviewed and found to be sufficient. Staff will be educated on Abuse and Abuse Prohibition and Resident Rights immediately and their inservice records will be updated to reflect this education. All residents have the potential to be affected. The facility's "Abuse Prevention" Policy was reviewed and found to be appropriate. Leadership staff were re-educated on Abuse Prevention (and reporting) Policy by RDCO. All staff members will be re-educated on this policy. Special emphasis was placed on the timeliness of reporting alleged events within 24 hours to ISDH. This education will be provided at all new hire orientation. A full audit of employee orientation	09/13/2013			

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	<p>information that could be located at the present time.</p> <p>On 8-19-13 at 9:55 a.m., the Administrator provided a copy of a policy entitled, "Abuse Prevention." This policy indicated, "All employees receive in-service training relative to resident rights and our facility's abuse prevention program policies and procedures. All employees are required to attend our facility's resident rights and abuse prevention program inservice training prior to having any resident contact..."</p> <p>This Federal tag relates to Complaint IN00132988.</p> <p>3.1-28(a)</p>		<p>records will be completed to identify any other deficits in education specific to new employee orientation.DON/designee will audit all new employee orientation records weekly to identify and correct any additional deficiencies. This audit will be performed weekly x 4 weeks and then monthly x5 months, and quarterly thereafter. Results of audits will be reviewed at QA committee meetings at least quarterly to ensure compliance maintained.</p>		

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F000243 SS=D	<p>483.15(c)(1)-(5) RIGHT TO PARTICIPATE IN RESIDENT/FAMILY GROUP</p> <p>A resident has the right to organize and participate in resident groups in the facility; a resident's family has the right to meet in the facility with the families of other residents in the facility; the facility must provide a resident or family group, if one exists, with private space; staff or visitors may attend meetings at the group's invitation; and the facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings.</p> <p>Based on interview and record review, the facility failed to ensure the Resident Council was able to meet with only the facility staff members invited by the Resident Council. This deficient practice affected 1 of 7 residents present for the 7-3-13 meeting. (Resident Council President and Administrator)</p> <p>Findings include:</p> <p>In an interview with the current Resident Council President on 8-20-13 at 2:30 p.m., she indicated she had resided at the facility for over 7 years and had been the council president for 5 to 6 months. She indicated the council meets monthly. She indicated shortly after the current Administrator came to this facility in June, 2013, there was a scheduled</p>	F000243	F243D-483.15(c)(1)-(5)RIGHT TO PARTICIPATE IN RESIDENT/FAMILY GROUP Facility leadership team re-educated on 'Resident Rights and Responsibilities' per RDCO. In particular, the resident has the right to organize and participate in residentgroups in the facility, and that staff or visitors may attend the meeting only at the group's invitation.All residents at the facility have the potential to be affected.The administrator and SSD met with the facility Resident Council President to apologize for his unwanted presence at previous resident council meeting, and assured her that he will only attend if invited to any future meetings of the Resident Council in the facility.RDCO provided re-education of facility leadership team pursuant to correct implementation of 'Resident Rights andResponsibilities' inregards to	09/13/2013	

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	<p>Resident Council meeting. She indicated the Administrator told her he had to be in the meeting. She indicated, "I told him, 'No,' he did not have to be in the meeting." She indicated the Administrator had the Social Services Director to take notes for the meeting. She indicated, typically, the Activities Director takes minutes for their meeting.</p> <p>She indicated she had spoken to the Administrator prior to the 7-3-13 meeting. She indicated she had told the Administrator at that time that he could come into the meeting to introduce himself, but he could not stay for the remainder of the meeting. She indicated the Administrator "remained even after I told him he did not have to stay." She indicated she had never had any prior Administrators remain for a meeting uninvited. She indicated she found this "nerve wracking." She indicated the other residents were not aware that the Administrator should remain only if invited. She indicated, "Nothing was put in the minutes [about him being there] because I think they were intimidated by [the Administrator.]"</p> <p>In interview with the Administrator on 8-20-13 at 3:00 p.m., he indicated he</p>		<p>presence of other staff members not invited to attend. Activities Director/designee is designated to be responsible for providing assistance and responding to written requests that result from group meetings. SSD/designee will audit and review monthly Resident Council Meeting Minutes and results will be forwarded to the QA committee for review and to ensure compliance maintained.</p>		

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	<p>had never been in a facility which had a Resident Council meeting without facility staff present. He indicated, "I would not have felt comfortable having just the activities assistant present and the Social Services Director was brand new." He indicated the Resident Council President indicated she did not want me present for the meeting." He indicated he shared with the Resident Council President that he wanted to make sure they had everything they needed for their meeting. He indicated he wanted to make sure they didn't have to cancel their meeting and that it was going appropriately. He clarified this by indicating he meant he wanted to ensure the resident's concerns were being heard and responded to by the facility.</p> <p>Review of the Resident Council Meeting Minutes for 7-3-13 and 8-14-13 indicated the minutes were written by the Social Services Director and the Administrator was listed as an invited guest.</p> <p>This Federal tag relates to Complaint IN00134006.</p> <p>3.1-3(j)</p>				

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F000431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>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.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>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.</p> <p>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.</p> <p>Based on observation, interview and record review, the facility failed to ensure safeguards were in place for medications as indicated by improper</p>	F000431	F431E-483.60(b), (d),(e)-DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 'Storage of Medications Policy' and 'Consultant Pharmacist	09/13/2013

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	<p>labeling of insulin and maintaining expired and/or non-physician ordered medications on 3 of 4 medication carts for 4 of 46 residents. (Resident #D, Resident #E, Resident #F and Resident #G)</p> <p>Findings include:</p> <p>1. During an observation of Medication Cart #1 on 8-19-13 at 11:25 a.m., 2 vials of Lantus insulin and 1 vial of Novolog, labeled for use for Resident #G were observed. One vial of Lantus insulin, with a pharmacy label date of dispense indicated as 7-9-13 and an expiration date of 12/14, was without its safety seal cap. The second vial of Lantus insulin, with a pharmacy label date of dispense indicated as 7-15-13 and an expiration date of 12/14, was without its safety seal cap. The vial of Novolog insulin, with a pharmacy label date of dispense indicated as 7-10-13 and an expiration date of 6/15, was without its safety seal cap. None of the 3 vials of insulin had a date indicated of when it had been opened for use.</p> <p>2. During an observation of Medication Cart #2 on 8-19-13 at 11:15 a.m., one bottle of spironalactone (used for high blood</p>		<p>Services Provider Requirements Policy' were reviewed and found to be sufficient. Medications improperly stored for those residents (D, E, F and G) were disposed of per policy and replaced if indicated. All residents have the potential to be affected by the deficient practice. Thus, a full audit of all medication carts was performed, no other deficiencies were found. The policies entitled "Storage of Medications" and "Consultant Pharmacist Services Provider Requirements" were provided via RDCO to DON and Pharmacy Consultant and reviewed. DON and Pharmacy Consultant verbalized understanding of policies. DON and Pharmacy Consultant will be auditing all medication carts to ensure compliance is maintained. DON/designee will perform weekly medication cart audits x 4 weeks, then monthly x 5 months to ensure all medications are stored, dated and disposed of per policy. In addition, Pharmacy Consultant will perform additional medication cart audits on all medication carts at monthly visits to ensure compliance maintained per policy. Results will be presented in Quality Assurance Meeting monthly until 100% compliance is achieved for one full quarter, then quarterly thereafter.</p>				

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	<p>pressure) 25 milligrams (mg) was observed to be labeled for Resident #F. The bottle of spironalactone was observed to have over 25 tablets present and had a "use by date" of 7-18-13. In an interview with LPN #2 on 8-19-13 at 11:25 a.m., she indicated this bottle of spironalactone was the current bottle being used by the facility for Resident #F's medication administration.</p> <p>3. During an observation of Medication Cart #2 on 8-19-13 at 1:55 p.m., one bottle of Milk of Magnesia was observed to be labeled for Resident #D. The bottle was observed to be unopened with the safety seal intact. The expiration date on the bottle was 7/13. Review of Resident #D's clinical record on 8-20-13 at 11:15 a.m. indicated this medication had not been renewed/continued by the physician upon readmission from a hospitalization on 5-24-13.</p> <p>4. During an observation of Medication Cart #3 on 8-19-13 at 2:35 p.m., one bottle of acetaminophen elixir, 160 mg per teaspoon, was observed to be labeled for Resident #E. This partially-used bottle was observed to have a pharmacy dispense date of 7-5-12 and a "use</p>						

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	<p>by" date of 7/13. There was no indication of what date the bottle was opened for use. Review of Resident #E's clinical record on 8-20-13 at 9:45 a.m. indicated a physician order had been received on 8-19-13 to discontinue this medication due to non-use of the medication.</p> <p>In an interview with LPN #2 on 8-19-13 at 2:00 p.m., she indicated the pharmacy consultant had been into the facility approximately one week prior to check the medication carts.</p> <p>On 8-20-13 at 8:25 a.m., the Administrator provided a copy of an untitled document regarding medication expiration dates that had been provided by the pharmacy consultant to the facility. This document indicated opened insulin products of Novolog and Lantus are satisfactory for use for 28 days after the date opened. It indicated tablets, capsules or liquids in the manufacturer's original container, whether opened or unopened, are satisfactory for use until the manufacturer's expiration date. It indicated tablets, capsules or liquids that have been repackaged are satisfactory for use for one year after the date of re-packaging.</p>			

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	<p>This Federal tag relates to Complaint IN00134006.</p> <p>3.1-25(o)</p>			
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F009999	<p>3.1-14 PERSONNEL</p> <p>(p) Initial orientation of all staff must be conducted and documented and shall include the following: (2) A review of residents' rights and other pertinent portions of the facility's policy manual. (4) A detailed review of the appropriate job description, including a demonstration of equipment and procedures required of the specific position to which the employee will be assigned.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure all staff hired within the last 120 days had received initial orientation training which included residents' rights, abuse prohibition education and receipt of a detailed job description for 2 of 5 employees who began employment within the last 120 days at the facility. (LPN #1, CNA #1)</p> <p>Findings include:</p> <p>1. During review of the staff personnel records on 8-20-13 at 1:23</p>	F009999	F9999-FINAL OBSERVATIONS-3.1-14PERSONNEL LPN#1's personnel file, and CNA#1's personnel file were reviewed. Their files were updated to include specific job descriptions, job related orientation checklists, documentation of in-service of 'resident rights' and abuse and abuse prohibition in-services. All employee files were audited and updated for job descriptions, job related checklists, resident rights, resident rights, and abuse and abuse prohibition education. RDCO educated facility leadership on 'State Employee Records Form', and system implemented immediately. In addition to the process noted above, the DON/designee will audit all new employee records weekly x 4 weeks, then monthly x 5 months for completion and compliance. Results will be presented in Quality Assurance Meeting monthly until 100% compliance is achieved for one full quarter .	09/13/2013			

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	<p>p.m., LPN #1's personnel record did not include documentation of inservice education for resident's rights or abuse prohibition education. Her record did not include documentation of receipt of her position-specific job description, nor did it include documentation of a job-specific orientation listing. LPN #1's record indicated her employment date was 5-3-13.</p> <p>2. Review of CNA #1's personnel record indicated she began employment on 6-28-13. Her record did not include documentation of receipt of her position-specific job description.</p> <p>In an interview with the Administrator on 8-20-13 at 3:15 p.m., he indicated the information provided was all of the information that could be located at the present time.</p> <p>On 8-19-13 at 9:55 a.m., the Administrator provided a copy of a policy entitled, "Abuse Prevention." This policy indicated, "All employees receive in-service training relative to resident rights and our facility's abuse prevention program policies and procedures. All employees are required to attend our facility's resident rights and abuse prevention</p>						

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NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION AND CONVALESCENT CENT	STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140
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(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>program inservice training prior to having any resident contact..."</p> <p>This State tag relates to Complaint IN00132988.</p> <p>3.1-14(p)(2) 3.1-14(p)(4)</p>			