STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155254	A. BUILDING 00 B. WING	06/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: June 20, 21, 22, 26, and 27, 2023. Facility Number: 000157 Provider Number: 155254 AIM Number: 100274720 Census Bed Type: SNF/NF: 40 Total: 40 Census Payor Type: Medicare: 1 Medicaid: 39 Total: 40 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 5, 2023	F 0000	This plan of correction is to serve as Sugar Creek Nursing and Rehabilitation Center's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Sugar Creek 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.	
F 0557 SS=D Bldg. 00	483.10(e)(2) Respect, Dignity/Right to have Prsnl Property §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. Based on observation, interview, and record	F 0557	**What Corrective Action(s) Will Be Accomplished For Those**	07/27/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Roger Brannan	Administrator	07/20/2023

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	review, the facility failed to provide a dignity bag to cover a catheter. This affected 1 of 3 residents reviewed for catheters. (Resident 13) Findings include: On 6/21/23, at 11:57 a.m., Resident 13 was observed sitting in a specialty chair, and the catheter bag was uncovered and hung from the underneath of the chair. During an observation, on 6/22/23, at 12:45 p.m., with the ADON, Resident 13's uncovered catheter bag hung from the side of her bed that faced the door. On 6/26/23, at 12:28 p.m., Resident 13 was seated in her specialty chair in the dining room and her catheter was uncovered and attached to the underneath of the chair. Resident 13's record was reviewed, on 6/22/23, at 10:44 a.m. The record indicated Resident 13 had diagnoses that included, but were not limited to, Parkinson's disease, high blood pressure, and anxiety. A Quarterly Minimum Data Set assessment, dated 5/8/23, indicated Resident 13 was cognitively intact, had an indwelling catheter, and did not walk. Resident 13 had physician's orders for a foley catheter, with a 14 French, 30 cubic centimeter balloon, to be changed on the 10th of every month and as needed. During an interview, on 6/26/23, at 1:35 p.m., the Director of Nurses indicated the CNA's and nurses were responsible to ensure resident		**Residents Found To Have Been Affected By The Deficient Practice:** Resident 13 will not have any adverse effects related to this alleged deficient practice. A dignity bag was placed over the urinary bag. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents have the potential to be affected by this alleged deficient practice. No other residents were affected by this alleged deficient practice. All residents with urinary catheters will have a dignity bag covering the urinary bag. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** All nursing staff will be in-serviced on the necessity to have dignity bags covering the urinary bag on July 21, 2023. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** DON/Designee will monitor the use of dignity bags daily on scheduled workdays times 4 weeks, then 2 times per week	

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	catheters are in dignity bags. A policy for "Quality of Life - Dignity", was provided by the Director of Nurses, on 6/27/23 at 9:55 a.m. The policy included, but was not limited to: "Policy Statement: Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Policy Interpretation and Implementation: 1. Residents shall be treated with dignity and respect at all times. 2. "Treated with dignity" means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth...11. Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by: a. Helping the resident to keep urinary catheter bags covered...." 3.1-3(t)		times 4 weeks, then weekly times 2 months, then monthly times 2 months. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly.	
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.			

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	§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing			

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	written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the			

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	grievance decision. Based on interview and record review, the facility failed to complete a grievance form to include the date of resident and/or responsible party notification of the resolution of a grievance and to list the disposition of the grievance for 1 of 2 residents reviewed for the grievance process. (Resident 22) Findings include: The clinical record for Resident 22 was reviewed on 6/26/2023 at 1:33 p.m. The medical diagnosis included quadriplegia. A Quarterly Minimum Data Set (MDS) Assessment, dated for 4/11/2023, indicated that Resident 22 was cognitively intact. A grievance form for Resident 22, dated for 6/20/2022, indicated that Resident 22 stated a staff member broke his tablet. The form did not indicate who the grievance was received by, department to resolve the issues, actions taken to resolve the outcome, date resolved, resolved by or date of the administrator's signature. An interview with Resident 22 on 6/26/2023 at 2:30 p.m. indicated he still did not know the resolution of the grievance for from June 2022. He stated a staff member had broken his tablet last year and the previous administrator kept telling him that he was going to get it fixed, but never did. The last conversation he had with the previous Administrator regarding this tablet was in November of last year. An interview with the Administrator on 6/27/2023 10:30 a.m. indicated that the grievance form for	F 0585	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** Resident 22 will not have any adverse effects related to this alleged deficient practice. Resident 22's tablet will be repaired if feasible, if not then tablet will be replaced. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents have the potential to be affected by this alleged deficient practice. No other residents were affected by this alleged deficient practice. All grievances will be completed per the facility policy and procedure. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** All staff will be in-serviced on July 21, 2023, over the facility grievance policy and procedure. All grievances will be completed per the facility policy and procedure. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:**	07/27/2023

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	Resident 22 dated 6/20/2022 was not completed per the protocol of the building. A policy entitled, "Grievances/Complaints, Recording and Investigating" was provided by the MDS Nurse on 6/26/2023 at 2:35 p.m. The policy indicated, " ...The Grievance Officer will record and maintain all grievances and complaints ...The following information will be recorded and maintained ...The date the residents, or interested party, was informed of the findings ..." The policy further indicated, " ...The residents, or person acting on behalf of the resident, will be informed of the findings of the investigation, as well as any corrective actions recommended, within 5 workings days of filing the grievance or complaint ..." 3.1-7(2) 3.1-7(3)(b)		The Administrator will monitor all grievances weekly for 8 weeks, then 2 times a month times 2 months, then monthly ongoing. Any negative findings will be corrected immediately and forwarded to the RDO. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview and record	F 0686	**What Corrective Action(s) Will**	07/27/2023

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	review the facility failed to implement pressure relieving boots as ordered by the physician for a resident with a pressure ulcer for 1 of 3 residents reviewed for pressure ulcer (Resident 12). Finding include: During an observation on 6/21/23 at 10:42 a.m., Resident 12 was laying in bed with heels/feet laying on the bed. The resident had pressure relieving boots laying in a chair in across his room. During an interview with the Director Of Nursing (DON) on 6/26/23 at 1:35 p.m., indicated the nurse and CNA's were responsible to ensure Resident 12 had his pressure relieving boots in place. Review of the record of Resident 12 on 6/27/23 at 11:30 a.m., indicated the resident's diagnoses included, but were not limited to, osteoarthritis, weakness, diabetes and dementia. The physician recapitulation for Resident 12, dated June 2023, indicated the resident was to wear bilateral pressure relieving boots at all times every shift for healing (5/18/23). The Admission Minimum Data Set (MDS) assessment for Resident 12, dated 5/24/23, indicated the resident was moderately impaired for daily decision making. The resident had no behaviors of rejection of care. The resident required extensive assistance of two people for bed mobility and transfers. The resident was at risk for developing pressure ulcers. The local wound center evaluation and management summary for Resident 12, dated		**Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** Resident 12 will not have any adverse effects related to this alleged deficient practice. Pressure relieving boots were applied to the resident's feet. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents have the potential to be affected by this alleged deficient practice. No other residents were affected by this alleged deficient practice. All residents with orders to wear pressure relieving boots will be wearing them. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** All nursing staff will be in-serviced on the facility's MD orders policy and procedure on July 21, 2023. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** DON/Designee will monitor the use of pressure relieving boots daily on scheduled workdays times 4 weeks, then 2 times per week times 4 weeks, then weekly	

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	6/15/23, indicated the resident had a wound on the left heel, right heel and right ankle. The resident had an unstageable Deep Tissue Injury (DTI) on the right lateral foot (partial thickness). The wound measured 7 centimeters (cm) by 2 cm. The wound was greater in depth and had deteriorated due to nutritional compromise. The wound assessment for Resident 12, dated 6/22/23, indicated the resident had a pressure ulcer on the right lateral foot measuring 7 cm by 2 cm. The wound bed was black/brown (eschar). The skin management policy provided by the DON on 6/27/23 at 9:55 a.m., indicated the resident would implement appropriate interventions to promote healing. 3.1-40(a)(2)		times 2 months, then monthly times 2 months. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly.	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;			

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	(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on observation, interview and record review the facility failed to maintain a Foley catheter in a manner to prevent Urinary Tract Infection (UTI) by keeping it from being in contact with the floor for 1 of 5 residents reviewed for catheter (Resident 12). Finding include: During an observation on 6/21/23 at 10:40 a.m., Resident 12 was laying in bed. The resident's urinary Foley catheter was laying on the floor at the foot of his bed with no dignity bag. During an interview with the Director Of Nursing (DON) on 6/27/23 at 1:35 p.m., indicated the CNA's and Nurses were responsible to ensure Resident 12's catheter was in a dignity bag and not laying on the floor. Review of the record of Resident 12 on 6/27/23 at 11:30 a.m., indicated the resident's diagnosis	F 0690	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** Resident 12 will not have any adverse effects from this alleged deficient practice. Residents 12's urinary Foley catheter was readjusted to keep it from touching the floor. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents have the potential to be affected by this alleged deficient practice. No other residents were affected by this alleged deficient practice. All	07/27/2023

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	included, but were not limited to, history of Urinary Tract Infection (UTI). The plan of care for Resident 12, dated 1/5/23, indicated the resident was at risk to develop a UTI related to having a history of UTI's and anchored Foley catheter. The plan of care of Resident 12, dated 1/5/23, indicated the resident had a Foley catheter related to stage 4 pressure ulcer on the coccyx. The Admission Minimum Data Set (MDS) assessment for Resident 12, dated 5/24/23, indicated the resident was moderately impaired for daily decision making. The resident had an indwelling Foley catheter. The Urinary Catheter policy provided by the DON on 6/27/23 at 9:55 a.m., indicated the purpose of the procedure was to prevent infection of the resident's urinary tract. The guidelines included, but were not limited to, "Be sure the catheter tubing and drainage bag are kept off the floor." 3.1-41(a)(2)		residents with orders for urinary Foley catheters will be applied to prevent them from touching the floor. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** All nursing staff will be in-serviced on urinary catheter policy and procedures on July 21, 2023. All residents with orders for urinary Foley catheters will be applied to prevent them from touching the floor. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** DON/Designee will monitor the proper placement of urinary Foley catheters daily on scheduled workdays times 4 weeks, then 2 times per week times 4 weeks, then weekly times 2 months, then monthly times 2 months. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly.	
F 0727 SS=D Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility			

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SUGAR CREEK REHABILITATION AND CONVALESCENT CENT	5430 W US 40 GREENFIELD, IN 46140

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	must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on interview and record review, the facility failed to ensure a Registered Nurse (RN) was utilized for at least 8 hours a day on 1/14/23, 1/28/23, 2/25/23, 3/25/23, 6/4/23, and 6/18/23, upon review on the daily schedules for June of 2023 and the Payroll Based Journal Staffing Data Report for the quarter of January 1, 2023, to March 31, 2023. Findings include: Upon review of the Payroll Based Journal Staffing Data Report, dated January 1, 2023, to March 31, 2023, indicated there were no RN hours for 1/14/23, 1/28/23, 2/25/23, and 3/25/23. Upon review of the daily schedules for June of 2023, the following days were noted without RN hours or partial hours: 6/4/23- no RN hours & 6/18/23- only 5.5 hours. An interview conducted with the Director of Nursing (DON), on 6/22/23 at 2:35 p.m., indicated there was no RN coverage on the dates of 1/14/23, 1/28/23, 2/25/23, and 3/25/23. On 6/18/23, the DON	F 0727	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** No residents were affected by this alleged deficient practice. The facility will have 8 consecutive hours of RN coverage 7 days a week. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents residing in the facility have the potential to be affected by this alleged deficient practice. No other residents were affected by this alleged deficient practice. The facility will have 8 consecutive hours of RN coverage 7 days a week. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To**	07/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155254	A. BUILDING 00 B. WING	06/27/2023

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

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	indicated she came in at 12:30 p.m. and stayed until 6:00 p.m. 3.1-17(b)(3)		**Ensure That The Deficient Practice Does Not Recur:** The facility will have 8 consecutive hours of RN coverage 7 days a week. Administrator and Administrative nursing staff will be in-serviced over regulation regarding required RN coverage. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** Administrator/Designee will monitor staffing on scheduled workdays daily ongoing to ensure appropriate daily RN coverage. Any negative findings will be corrected immediately and forwarded to the Regional Director of Operations. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly.	