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	10/03/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00135415 and IN00135310. Complaint IN00135415 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00135310 - Substantiated. Deficiencies related to the allegations are cited at F9999. Dates of Survey: September 25, 26, 27, 30, October 1, 2, and 3, 2013 Facility number: 000157 Provider number: 155254 AIM number: 100274720 Survey team: Karina Gates, Generalist TC Courtney Mujic, RN (September 25, 26, 30, October 1, 2, and 3, 2013) Barb Gray, RN (October 3, 2013) Angel Tomlinson, RN (October 3, 2013) Leslie Parrett, RN (October 3, 2013) Census bed type: SNF/NF: 44 Total: 44	F000000	This plan of correction is to serve as Sugar Creek Rehabilitation and Convalescent Center's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Sugar Creek Rehabilitation and Convalescent Center or its management company that allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in the facility, not does this submission constitute an agreement or admission of the survey allegations. We respectfully request a paper review of this plan of correction.	

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

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	Census payor type: Medicare: 5 Medicaid: 28 Other: 11 Total: 44 These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed on October 17, 2013, by Janelyn Kulik, RN.			

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F000167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. Based on observation, record review, and interview the facility failed to ensure survey results were readily accessible to all residents. This had the potential to affect all residents who reside in the facility. Findings include: An interview with the Resident Council President, on 10/2/2013 at 11:12 a.m., indicated, "I didn't know we could see the results of the state inspection reports." An observation of the Administrator's office door, on 10/2/2013 at 11:40 am.., indicated a hanging file container outside the door, on the left side, at standing eye-level or approximately 4.5 feet from the ground. There was no sign or label on the hanging file but inside there was a binder labeled, "state survey results"	F000167	F167 483.10(g)(1)Right to Survey Results – Readily Accessible I. The notebook containing the survey results is labeled. The hanging container was lowered to wheelchair level. II. All facility residents could be at risk for this practice. A Resident Council Meeting was held on Monday, October 28, 2013 during which the right to review the survey and the location of the information were discussed.III. The agenda for Resident Council meeting will include the right to review the survey results and the location of the information. This will be discussed quarterly for six months. IV. The administrator will monitor the hanging file holder for appropriate labels and contents. Corrections will be made as needed. This will occur weekly x 4 weeks then monthly thereafter x 5 months. Results will be reviewed and monitored by facility QA committee quarterly.V. November 2, 2013	11/02/2013

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	An interview with the resident council president, on 10/2/2013 at 11:45 a.m., indicated, "Oh, its right by the Administrators office? They haven't told us because they didn't want us to know we could read it." An interview with the Administrator, on 10/2/2013 at 2:10 p.m., indicated, the survey results have been kept here since he started. 3.1-3(b)(1)			

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F000225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F000225	F225 483.13(c)(1)(ii-iii), (c)(2)-	11/02/2013

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	Based on interview and record review the facility failed to report an allegation of abuse to the appropriate state agencies, including Adult Protective Services and the Ombudsman, for 1 of 3 incidents reviewed. Findings include: Review of an Indiana State Department of Health Incident Report Form (Follow-up Report), dated 9/23/2013, indicated, "Date of Incident: 9/18/2013...Immediate Action Taken:...Family, Physician, Administrator and Director of Nursing notified immediately. Investigation has been initiated. Investigation Results:...There was sufficient evidence to substantiate the complaint of verbal abuse, rudeness, intimidation and poor communication practices." An interview with the Administrator, on 10/3/2013 at 2:45 p.m., indicated he did not report the incident to Adult Protective Services or the Ombudsman because"that hasn't been the practice of this building as far as I'm aware." An "Abuse Prevention" policy and procedure, provided by the		(4) I. Adult Protective Services and the Ombudsman were notified of the incident dated 9/18/13 on 11/1/13.II. All residents have the potential to be affected by this practice. There have been no further incidents to this date.III. The facility policy entitled “Abuse Prevention” was reviewed and found to be sufficient. The facility Administrator will notify Adult Protective Services and the Ombudsman for all abuse allegations when reporting to ISDH. The notification of Adult Protective Services and the Ombudsman will be documented in the ISDH 5 day follow up report.IV. The Administrator and the Director of Nursing will review the ISDH reports for accurate information and reporting to appropriate agencies per policy. ADM/designee will audit this process monthly x 6 months, and results will be reviewed and monitored by facility QA committee quarterly.V. November 2, 2013	

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	Administrator, on 9/25/2013 at 1 p.m., indicated, "V. Abuse Investigations. Policy Intrepretation and Implementation. 10. Should the investigation reveal that abuse occurred, the administrator will report such findings to the ombudsman, the state licensing agency and others as may be required by state or local laws within 24 hours of the results of the completion of the investigation." 3.1-28(c)			

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F000226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review the facility failed to report an allegation of abuse to the appropriate state agencies, including Adult Protective Services and the Ombudsman, for 1 of 3 incidents reviewed. Findings include: Review of an Indiana State Department of Health Incident Report Form (Follow-up Report), dated 9/23/2013, indicated, "Date of Incident: 9/18/2013...Immediate Action Taken:...Family, Physician, Administrator and Director of Nursing notified immediately. Investigation has been initiated. Investigation Results:...There was sufficient evidence to substantiate the complaint of verbal abuse, rudeness, intimidation and poor communication practices." An interview with the Administrator, on 10/3/2013 at 2:45 p.m., indicated he did not report the incident to Adult Protective Services or the	F000226	F226 483.13(c) Develop/Implement Abuse/Neglect, ETC Policies I. Adult Protective Services and the Ombudsman were notified of the incident dated 9/18/13 on 11/1/13. II. All residents have the potential to be affected by this practice. There have been no further incidents to this date. III. The facility policy entitled "Abuse Prevention" was reviewed and found to be sufficient. The facility Administrator will notify Adult Protective Services and the Ombudsman for all abuse allegations when reporting to ISDH. The notification of Adult Protective Services and the Ombudsman will be documented in the ISDH 5 day follow up report. IV. The Administrator and the Director of Nursing will review the ISDH reports for accurate information and reporting to appropriate agencies per policy. ADM/designee will audit this process monthly x 6 months, and results will be reviewed and monitored by facility QA committee quarterly. V. November 2, 2013	11/02/2013

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	Ombudsman because"that hasn't been the practice of this building as far as I'm aware." An "Abuse Prevention" policy and procedure, provided by the Administrator, on 9/25/2013 at 1 p.m., indicated, "V. Abuse Investigations. Policy Intrepretation and Implementation. 10. Should the investigation reveal that abuse occurred, the administrator will report such findings to the ombudsman, the state licensing agency and others as may be required by state or local laws within 24 hours of the results of the completion of the investigation." 3.1-28(c)			

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F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, interview and record review, the facility failed to ensure a resident receiving an antipsychotic had a care plan for its use and a resident with a dental condition had a dental care plan for 2 of 16 residents reviewed for care plans. (Resident #19 and 30). Findings include: On 9/26/13 at 1:49 p.m., Resident #19 was observed with heavy plaque and debris in between and on his teeth as well as with some missing	F000279	F279 483.20(d), 483.20(k)(1)Develop Comprehensive Care Plans I. A care plan was developed for resident #19 related to mouth care and dental treatment. A care plan was developed for resident #30 related to dose reduction of Zyprexa and included monitoring and assessment for behaviors and side effects.II. All residents were at risk for care plan omissions. Care Plans were reviewed for accuracy. Behavior/Antipsychotics care plans were developed/reviewed as needs were identified during assessment or during the daily	11/02/2013

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	teeth. The clinical record for Resident #19 was reviewed on 10/1/13 at 1:30 p.m. The 6/25/13 Nursing Home Encounter dental exam for Resident #19 indicated teeth #1 and 17-32 were "Missing Teeth". It indicated teeth #9 and 10 were "Teeth for Extraction." The bottom of the exam dictated, "heavy cervical build-up....if pt (patient) desires tx (treatment) transport for periol ext (exterior) & restorative...poss (possible) abscess #14...rec (recommend) transport for x-rays & tx." There was no information in the clinical record to indicate Resident #19 received any further dental treatment beyond the 6/5/13 exam. The 7/10/13 Plan of Care Conference Summary indicated, "needs dental work." During review of Resident #19's care plans, no dental care plan was found. During an interview with the Director of Nursing on 10/2/13 at 1:05 p.m. regarding lack of a dental care plan for Resident #19, she indicated, "He should have a dental care plan. I think I'll have the dentist send us		clinical meeting. III. Facility policies entitled “Interdisciplinary Team Process” and “Behavior Tracking” were reviewed and found to be sufficient. The care plans will be reviewed for relevance, goals and appropriate interventions based on the MDS assessment schedule and observations, behavior tracking tool conditions. IDT team will review these changes and revise plans of care during the morning Clinical Meeting per policy.IV. The DON/designee will audit the completion of 5 random behavior/antipsychotic meds care plans weekly for 4 weeks, then monthly x 5 months to ensure compliance. The Director of Nursing will attend the scheduled care plan conference and audit the content of the care plan for accuracy weekly x 4 weeks, then monthly x 5 months. Results will be reviewed and monitored by facility QA committee quarterly.V. November 2, 2013	

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	some notes, and we can move forward from there." 2. The clinical record for Resident #30 was reviewed on 10/2/13 at 12:15 p.m. The diagnoses for Resident #30 included, but were not limited to: dementia with behaviors. The September, 2013 MAR (medication administration record) indicated Resident #30 received 10 mg of zyprexa (an antipsychotic medication) daily everyday of the month. During review of Resident #30's care plans, no care plan could be found addressing her behaviors or her zyprexa use. During an interview with the SSD (Social Services Director) on 10/2/13 at 12:15 p.m. regarding whether Resident #30 had a behavior care plan she indicated Resident #30 did not have a behavior care plan and stated, "I've never seen any behaviors. She came to us with the diagnosis of dementia with behaviors. Family said they don't know why, because she's never had any behaviors			

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	During an interview on 10/2/13 at 12:25 p.m. with the Director of Nursing, DON, regarding Resident #30's zyprexa use she indicated, "As long as she doesn't continue to have behaviors, our goal is to get her off of it. I anticipate she'll be able to come off of it. We'll probably try another reduction on her at her next review..." During an interview with the MDS Coordinator on 10/2/13 at 12:31 p.m., she stated, "She should have a zyprexa care plan that indicates monitor for increased behaviors, signs and symptoms of adverse consequences...It was the previous DON's responsibility, and she didn't do it." 3.1-35(a)			

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F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to provide a Nepro shake to a resident and take a resident's blood pressure per physicians' orders for 2 of 16 residents reviewed for following physician's orders. (Resident #31 and 33) Findings include: 1. The clinical record for Resident #31 was reviewed on 10/3/13 at 11:00 a.m. The diagnoses for Resident #31 included, but were not limited to: paraplegia, stage 5 chronic kidney disease, and diabetes mellitus. The October, 2013 Physician's Orders for Resident #31 indicated, "Nepro shake 1 can by mouth after lunch daily" effective 9/13/13. An observation of Resident #31 receiving her lunch tray in her room was made on 10/3/13 at 12:31 p.m. No Nepro shake was delivered.	F000282	F282 483.20(k)(3)(ii)Services By Qualified Persons/Per Care Plan I. The Nephro for resident #33 was discontinued due to resident refusal. Nephro is not provided with chocolate flavoring. The order for resident #33 to have blood pressure taken daily was changed to weekly. The blood pressure has been recorded weekly.II. Residents receiving supplements or who require specifically timed assessments are at risk for the practice. The MAR's and TAR's were reviewed for completion and accuracy of physician orders transcription. Scheduled orders were bracketed for easy identification.III. Orders are reviewed each month for accuracy. Treatments or assessments ordered on specific days or schedules are bracketed on the MAR/TAR. Supplement orders include a designated area on the MAR for documentation of the percent the resident consumes. IV. The Director of Nursing will audit the 8 MAR's weekly x 8 weeks, then monthly x 4 months to ensure orders are recorded accurately. Results will be reviewed and monitored by facility QA committee	11/02/2013

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	Regarding the Nepro shakes, Resident #31 stated, "I will not drink that stuff. They only have vanilla. I've never seen them with the chocolate. I'll drink a really cold chocolate one. I told them a couple days ago I don't want it until they can get me chocolate. They bring it on my tray. They haven't brought it to me since. I think they're hard headed." The October, 2013 MAR (medication administration record) for Resident #31 indicated she received the Nepro shake on 10/2/13 and 10/3/13. During another interview with Resident #31 on 10/3/13 at 3:35 p.m. she stated, "I did not get the shake today or yesterday, and I will not get it until it's chocolate." On 10/3/13 at 3:37 p.m., an interview was conducted with LPN #3, who signed the above MAR for receipt of the Nepro shake on 10/2/13 and 10/3/13. She indicated, "It's supposed to be delivered on her lunch tray. I signed off on the MAR that she got it today and yesterday because I was trusting that the restorative aide gave it to her." LPN #3 pointed to the vanilla Nepro shakes located in a box on top of a		quarterly.V. November 2, 2013	

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

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	filing cabinet in the nurses station. No chocolate shakes were observed. During an interview with QMA #4, also at the nurses station on 10/3/13 at 3:37 p.m., she indicated, "I know she refuses it, because she only likes chocolate." 2. On 10/3/13 at 10:30 a.m. review of Resident # 33's record indicated the diagnoses included but were not limited to, dementia of Alzheimer's type with behavioral disturbance, hypertension, history of cardiovascular accident, osteoporosis, depression and psychosis. The Physician's recapulation orders dated 9/1/13 through 9/30/13 indicated amlopine 5 mg every day for hypertension (started (8/14/13) metoprolol 25 mg twice a day for hypertension (started 8/9/13) check blood pressure daily times 1 week then weekly, hypertension, call Nurse Practioner for systolic >160 <90 (started 8/13/13) Review of a Physician's order dated 9/17/13 indicated blood pressure every day, HTN(hypertension) call systolic B/P (blood pressure) <90 >160.			

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	The Medication Record dated 9/1/13 through 9/30/13 indicated no blood pressure checks were documented for the month of September. On 10/3/13 at 1:05 p.m. interview with the Director of Nursing indicated the blood pressures checks were not documented or completed as ordered. 3.1-35(g)(2)			

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F000314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on interview and record review, the facility failed to implement preventive measures per facility policy to maintain skin integrity and perform weekly skin assessments per physician's orders for 1 of 2 residents reviewed of 2 who met the criteria for pressure ulcers. (Resident #31) The clinical record for Resident #31 was reviewed on 10/3/13 at 11:00 a.m. She was admitted to the facility on 7/8/13. The diagnoses for Resident #31 included, but were not limited to: paraplegia, stage 5 chronic kidney disease, and diabetes mellitus. During an interview with LPN #2 on 9/26/13 at 11:09 a.m., she indicated Resident #31 had a stage 2 pressure ulcer on her coccyx and a stage 2	F000314	F314 483.24(c)Treatment/SVCS to Prevent/Heal Pressure Ulcers I. The Director of Nursing and the charge nurse assessed the wound and the resident's skin. A care plan was developed which included all of the measures currently in place. A preventative care plan was also completed for resident #31. The resident and family received education regarding positioning. The ambulance service was notified to provide a pressure relief pad for the resident during transfer to and from dialysis.II. All residents admitted to the facility with a risk for or who have actual wounds were at risk for this practice. Facility policy entitled "Weekly skin assessment" and "Weekly skin assessment sheet" were reviewed and found to be sufficient. Education was provided to the nurses on 10/14/13 related to wound prevention measures, care plan development, Braden	11/02/2013

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	pressure ulcer on her left buttock. The 7/8/13 Pressure Ulcer Risk assessment for Resident #31 indicated the following: Sensory Perception-very limited, Activity-chairfast, Mobility-completely immobile, Friction and Shear-problem (Moderate/maximum assist in turning. Frequently slides down in bed/chair. Spasticity/contractures/agitation leads to constant friction.) She had a risk score of 10, indicating she was at high risk for pressure ulcers. The 7/18/13 Admission MDS (minimum data set) assessment indicated Resident #31 was at risk for pressure ulcers, had no current open areas, and pressure ulcers were addressed in a care plan. It indicated she was total dependence of 2 plus persons for bed mobility and had lower extremity impairment on both sides for range of motion. It also indicated she had a BIMS (brief interview for mental status) score of 15 (highest possible score indicating a resident is cognitively intact.) Review of Resident #31's care plans indicated skin integrity was not addressed in a care plan until 7/23/13 on the nutrition care plan.		assessments for four weeks post admission and initial and weekly skin assessment. Education was provided to the certified nursing assistants related to weekly skin assessments, turning and positioning and pressure relief devices on 10/16/13.III. An initial skin assessment is conducted on admission. Residents determined to be at risk for or who have skin break down have measures in place to assist in prevention or healing. The initial care plan will be completed within 24 hours of resident admission which includes prevention and/or healing measures. The four Braden Scale assessments are placed in the MAR for ease of documentation. In addition, weekly skin assessments will be completed by designated staff and monitored by DON/designee to ensure adherence to policy.IV. The Director of Nursing will perform an admission chart audit on the next business day after resident admission to determine if all areas of risk assessment have been identified and a care plan is developed. The completion of the four Braden Scale assessments post admission will be audited for completion weekly x 8 weeks, then monthly x 4 months to insure compliance. Results will be reviewed and monitored by facility QA committee.V. November 2, 2013	

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	No weekly skin assessments could be found in the clinical record. The 7/23/13 IDT (Interdisciplinary) Progress Note indicated, "IDT wound review: skin assessment completed. O/A (open area) noted to coccyx. Area measures 1.2 cm L (length) x 1 cm W (width) x 0.1 cm D (depth). Wound bed pink (symbol for "with") 100% epithial (sic) cells. No drainage noted. No undermining or tunneling (sic). Res (resident) denies pain. Calmoseptine applied as ordered. (Symbol for "right") heel noted to be slightly red. Res states her heel & coccyx have a history of breaking down. Order received for skin prep to (right) heel QS (every shift). Will continue to monitor." The 7/29/13 IDT progress note indicated the open area to her coccyx was bigger, measuring 2 cm x 1 cm x 0.1 cm. During an interview with the DON (Director of Nursing) on 10/3/13 at 11:38 a.m. regarding preventive measures taken to maintain Resident #31's skin integrity after admission, given her high risk for pressure ulcers, she indicated, "There are no interventions found in this chart. They were not doing any			

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	admission/interim care plans...To my knowledge, the first skin care plan in place for her was 7/23/13. I don't see anything on skin until the addition on the nutrition care plan on 7/23/13. She's on a low air loss mattress now." Regarding her expectation for skin assessments, she indicated, "My expectation for weekly skin assessments is that the nurse looks and assesses the skin during the shower/bed bath. I'll get the policy. I don't know what the process is here to be honest. I would expect that the nurse do a skin assessment weekly in some manner." Regarding how Resident #31's skin was actually being monitored after admission, she indicated, "I'll research that." During another interview with the DON on 10/3/13 at 12:09 p.m., she indicated, "We could not find a care plan from 7/8/13 to 7/23/13. We can't find any shower sheets for her from 7/8/13 to 7/23/13. I can't find any information about maintaining her skin integrity until the 7/23/13 nutrition care plan. There's no weekly skin assessments at all. There's an order for skin assessments and it's on the MAR (medication administration record), but it's blank. " During an interview with Resident #31			

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	on 10/3/13 at 12:24 p.m. regarding her pressure ulcer, she indicated, "I didn't have a low air loss mattress when I was admitted. I do now. I have had it for a couple of weeks. They said it (my sore) was getting better. My sister said it was too, about a week ago. They could have turned me more often. It wasn't every 2 hours. They would only turn me if I asked. I would start to feel weird on my bottom. I told my sister I felt like I was getting a sore on my bottom. She looked at it and said "yes". She told them (the facility) I had one. This was in July." The 7/30/13 nurses note indicated, "(Name of physician) after seeing this resident, has given orders for her to be sent to (name of hospital) for work up for sepsis..." The 8/22/13 IDT note indicated, "Res (resident) readmitted to our facility on 8/16/13 from (name of hospital)....No skin issues noted..." The 9/13/13 IDT note indicated, "IDT wound review: buttocks measures 1.8 cm x 0.8 cm x 0.3 cm depth. Actively bleeding. Tissue around wound bed is pink as well as the center. Tx (treatment) as ordered wound gel with dry drsg to all open			

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	areas..." The only care plan specifically addressing Resident #31's pressure sore was dated 9/1/13 with a goal of "heal open areas" and interventions as "wound gel (symbol for "with") dry drsg (dressing) to open areas q (every) shift, monitor open area." No other interventions were indicated on the care plan. The September and October, 2013 Physician's Orders indicated, "Skin assessment weekly on 1st shower day of the week" effective 8/15/13. The September and October, 2013 MAR's did not indicate this was done at all either month. The Prevention of Pressure Ulcers policy was provided by the DON on 10/3/13 at 1:15 p.m. It indicated, "Complete the Braden Scale on all residents on admission to the facility and weekly for the 1st 4 weeks of admission...For a person in bed: a. Change position at least every two hours or more frequently if needed...3. For a person in a chair: a. Change position at least every hour...9. Routinely assess and document the condition of the resident's skin. Residents identified to be at risk for pressure ulcer			

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	development should have a skin assessment completed at least weekly." On 10/3/13 at 1:15 p.m. the DON indicated, "We have a Braden for admission, but not the subsequent 4 weeks." 3.1-40(a)(1)			

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F000412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on observation, interview and record review, the facility failed to follow through with dental recommendations for 1 of 1 residents reviewed of 1 who met the criteria for dental status and services. (Resident #19) Findings include: On 9/26/13 at 1:49 p.m., Resident #19 was observed with heavy plaque and debris in between and on his teeth as well as with some missing teeth. The clinical record for Resident #19 was reviewed on 10/1/13 at 1:30 p.m. The 6/25/13 Nursing Home Encounter dental exam for Resident #19 indicated teeth #1 and 17-32 were "Missing Teeth". It indicated teeth #9	F000412	F412 483.55(b)Routine /Emergency Dental Services in NFS I. Resident #19 was assessed and treated by the dentist on Wednesday, October 9, 2013 with Dr. Ball.II. Residents requiring off site specialty services are at risk for the practice. The Social Services Director will calendar and arrange the recommended appointments for additional treatment.III. The Social Services Director will receive the assessments and recommendations from ancillary services as they exit the facility. A copy of the information is made and forwarded to the Director of Nursing for review. The Social Services Director makes note of any follow-up needed and calendars the information after arrangements are made. The Social Services Director places the information in the medical record. IV. The Director of Nursing and the Administrator will monitor the compliance of this	11/02/2013

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	and 10 were "Teeth for Extraction." The bottom of the exam dictated, "heavy cervical build-up....if pt (patient) desires tx (treatment) transport for periol ext (exterior) & restorative...poss (possible) abscess #14...rec (recommend) transport for x-rays & tx." There was no information in the clinical record to indicate Resident #19 received any further dental treatment beyond the 6/5/13 exam. The 7/10/13 Plan of Care Conference Summary indicated, "needs dental work." An interview was conducted with the DON (Director of Nursing) on 10/1/13 at 2:00 p.m. regarding follow up to the 6/25/13 dental recommendations. She indicated, "I'm not sure. I'll have to look into it." Interview conducted with the DON the following day on 10/2/13 at 1:05 p.m. indicated, "We called the dentist, and they said they would not see him without Medicaid approving him. The dentist said they have the approval, and now he has an appointment on 10/9/13 to fix the tooth (tooth #14). I think what happened was (name of Social Services Director), did not have a system in place to follow up		plan by way of the Interdisciplinary Team Process in the daily clinical meeting and review of the Social Services calendar. This will be reviewed by facility QA committee quarterly.V. November 2, 2013	

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	and see if there was approval. I don't think it was a health issue, but it should have been followed up on. (Name of Resident #19) said he was fine with the appointment." She indicated she was unsure exactly how long the dentist had the necessary Medicaid approval. The 10/1/13 social services note indicated, "Writer was informed on 6/26/13 dentist office would call and verify an appointment after receiving Medicaid approval. Writer called 10/1/13 to follow-up and resident is scheduled for an appointment on 10/9/13 at 1:45 p.m. for a 2 hour procedure..." 3.1-24(a)(1)			

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F009999	State Findings 3.1-14 PERSONNEL (b) A facility must not use any individual working in the facility as a nurse aide for more than four (4) months on a full-time, part-time, temporary, per diem, or other basis unless that individual: (1) is competent to provide nursing and nursing related services, and: (2) has completed a: (A) training and competency evaluation program; or (B) competency evaluation program approved by the division. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure a CNA (Certified Nursing Assistant) received her Indiana certification within 120 days of her hire date for 1 of 5 CNA's reviewed for appropriate certification. (CNA #1) Findings include: On 10/2/13, at 11:00 a.m., the Medical Records Manager provided	F009999	F9999 3.1-14 Personnel I. CNA #1 no longer being used as a CNA by the facility. The facility will ensure the completion of training and competency evaluation of all clinical staff prior to date of hire.II. HR/designee will copy clinical staff licenses and place in the employment file at the time of hire. Any issues will be reported to ADM/designee prior to employee start date. The CNA's standing with the board of nursing will be evaluated through online services.III. Human Resources will review new hire files prior to the first day of work for all required licenses and education certificates. IV. DON/designee will audit new employee files of all new staff members weekly x 4 weeks then monthly x 5 months to ensure compliance. Results will be forwarded to facility QA committee for review.V. November 2, 2013	11/02/2013

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	the Employee Records form and personal files for 5 CNA's listed as working in the facility. CNA #1 had a start date of 3/29/13. Upon review of CNA #1's file, no Indiana nurse aide certification was found. An interview was conducted with the Medical Records Manager on 10/3/13 at 3:00 p.m. She provided written verification that CNA #1 took the Indiana CNA test and failed the written portion on 4/1/13. She indicated she was under the impression that CNA #1 was allowed to work for 180 days with her out of state certification, so long as she took the Indiana test in that time frame. She further indicated she was under the impression that, so long as CNA #1 passed a portion of the Indiana CNA test, but not the test in its entirety, she could work an additional 180 days, for a total of 360 days, before she was required to obtain her Indiana CNA registration. She indicated the facility did not have this procedure in writing. This state tag relates to Complaint #IN00135310.			

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