STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/26/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00371573 and IN00371581. This visit included a Residential COVID-19 Quality Assurance Walk-Through. Complaint IN0000371573- Substantiated. State Residential Findings are cited at R0036, and R0407. Complaint IN0000371581- Substantiated. State Residential Findings are cited at R0036, R0154, and R0407. Survey dates: January 25 and 26, 2022 Facility number: 012394 Residential Census: 108 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on Febraury 4, 2022.	R 0000		
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.			

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

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	Based on observation, interview, and record review, the facility failed to inform families of residents' change in condition for 2 of 6 residents reviewed for notification (Resident C and D) and the facility failed to notify resident families and representatives of positive COVID-19 cases in the facility for 1 of 2 months reviewed for notification of COVID-19. Findings include: 1. During an interview, on 1/25/22 at 1:50 p.m., Licensed Practical Nurse (LPN) 6 indicated from Monday to Wednesday there had been 12 residents throughout the building including the memory care unit with the same gastric symptoms. The symptoms included nausea, vomiting, and diarrhea. Resident C had gone to the hospital with these gastric symptoms and had tested positive for norovirus at the hospital. LPN 6 and Qualified Medication Aide (QMA) 5 indicated they did not document symptoms or call families when residents developed these symptoms. If a resident required new treatment they would call, but otherwise they did not. a. On 1/25/22 at 2:58 p.m., the grievance report, dated 1/21/22, was provided by the interim Executive Director (ED). The ED indicated the grievance was written on 1/25/22 based on the situation on 1/21/22. The family of Resident C filed the grievance. The grievance indicated, "Family was upset they were not notified of resident not feeling well...family states that they had contacted ambulance to transfer him to hospital for evaluation on 1/21/22. Family says no communication was received despite leaving messages with nurses for follow up prior to him being transferred to hospital. Family states they have had difficulties with communication	R 0036	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion stated on the statement of deficiencies. This statement of correction is prepared and submitted solely because of requirements under state and federal laws. We cordially request a desk review regarding the alleged deficiencies in lieu of any revisit. 1. Residents and families are now being notified of COVID status in the building and families and MDs are now being notified of condition changes with residents as changes of condition occur. 2. An audit of COVID notifications to residents and families over the past two months will be completed. Also, an audit of 100% of residents will be conducted to determine if there have been recent condition changes and if notification was made to MD and family. Notifications as appropriate will be made in accordance with the audit findings. These audits will be completed by 2/25/22. 3. As new leadership is hired into the community, training will be provided to the new leadership	02/25/2022

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	before...." During an interview, on 1/26/21 at 10:28 a.m., the family of Resident C indicated another family member had heard a rumor there was a "stomach bug" in building and Resident C had it. The facility had not called the family to inform them. The family went to the facility and Resident C had diarrhea, vomiting, and was weak. The family emailed the Director of Nursing (DON) that Resident C had a change in condition and the family was not notified. The DON responded that she was unsure why staff did not call the family, but the DON was not in the building due to being quarantined. The family indicated the facility staff never call about anything related to Resident C. The facility staff did not notify him of things in person when he visited twice a week. It was "aggravating" if Resident C was sick then the family should be aware. They family called an ambulance to take Resident C to the hospital. Resident C was diagnosed with a urinary tract infection (UTI), pneumonia, and norovirus. The family brought the resident back from the hospital and stayed with the resident. The next day the hospital called and informed the family Resident C had norovirus and it was very contagious. The family informed the nursing staff of the lab result and told them to notify the DON since it was contagious. On 1/26/22 at 3:25 p.m., Resident C's record was reviewed. Physician Visit Note, dated 1/14/22, indicated the resident was seen for leg/feet swelling. The resident had chronic urinary retention and/or hesitancy. Symptoms were alleviated by medication and indwelling urinary catheter.		regarding notification of cumulative total of COVID confirmed cases and information on mitigating efforts to residents and families. This training will be completed the first week of hire for new Executive Director. All licensed nurses in the community will be educated on the state regulation and Community policy entitled “Significant Condition Change & Notification.” All community licensed nursed will be educated by 2/25/22 and agency licensed nurses will be educated prior to their scheduled shift. 4. Regional staff will ask for copies of notification of COVID confirmed cases that have been distributed to residents and families on a weekly basis. DON/designee will learn of resident condition changes each morning during morning rounds and will audit the records for notification to MD and Families 5 days/week for one month, then weekly for one month. 5. Executive Director/Designee, in collaboration with Director of Nursing/Designee will review audits with QA Committee monthly x3 months for identified issues. QA Committee will determine if audits necessitate extension past 3 months and will continue to review audit results monthly for	

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	Nurses' notes, dated 1/21/22 at 10:30 p.m., indicated Resident C arrived on the evening shift. His lungs were assessed as wheezing and diminished lung sounds. There was no confusion noted. Resident C had been sent to the emergency room (ER). The ER discharged the resident with diagnoses of pneumonia in bilateral lungs. Nurses' notes, dated 1/22/22 at 7:08 a.m., indicated Resident C was placed on contact isolation related to the new diagnosis of norovirus. Nurses' notes, dated 1/23/22 -1/25/22, indicated Resident C was on contact isolation for norovirus and on antibiotics for an UTI and pneumonia. Resident C's record lacked documentation of nausea, vomiting, and diarrhea, and lacked documentation of notification to the physician or family for these symptoms. b. During an interview, on 1/26/22 at 11:40 a.m., the family of Resident D indicated when they came to visit 1/21/22 and they found out during the visit Resident D had a "stomach bug" by observing the resident having diarrhea and then asking the nursing staff about her symptoms. No one contacted the family. On 1/26/22 at 3:06 p.m. Resident D's record was reviewed. An admission evaluation and assessment indicated the resident was able to propel self in a wheelchair, able to state her name and was oriented to person and place. A Nurses' note, dated 1/22/22 at 10:30 a.m., indicated Resident D' family was at the bedside		duration of the extended timeframe as applicable. Date of completion: February 25, 2022	

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	and the resident did not complain of diarrhea during the shift. The record lacked documentation of the resident's gastric symptoms on 1/21/22 and lacked documentation of notification of the family or physician. The Medication Administration Record, for January 2022, indicated Resident D received one dose of Imodium on 1/21/22 which was originally ordered for an as needed medication on 5/28/20. During an interview, on 1/26/22 at 12:55 p.m., LPN 8 indicated she worked on the dementia unit regularly. There were several residents that had had gastric symptoms of vomiting and diarrhea recently. If a resident had those symptoms, she had obtained orders for Imodium (medication for diarrhea) and Zofran (medication for nausea and vomiting) if they did not have orders already. She was unsure if families had been notified. On 1/26/22 at 2:34 p.m., the Regional Nurse provided the current undated policy titled, "Significant Condition Change & Notification." The policy indicated, "...ensure that the resident's family and/or representative and medical practitioner are notified of resident changes such as those listed below...emesis/diarrhea...mobility changes ...symptoms of an infectious process...other abnormal assessment findings...when any of the above situations exists, the licensed nurse will contact the resident's representative and their medical practitioner...." 2. During an interview, on 1/25/22 at 1:50 p.m., Licensed Practical Nurse (LPN) 6 and Qualified Medication Aide (QMA) 5 indicated they were			

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	unaware if families and residents were notified of COVID-19 cases in the building. There was a sign in the lobby near the reception desk that indicated how many residents and staff were positive. During an interview, on 1/26/21 at 10:28 a.m., the family for Resident C indicated staff never called about anything related Resident C. The family did not receive calls regarding anything at the facility. The family was not told anything regarding the resident or COVID-19 when they visited twice a week. During an interview, on 1/25/22 at 3:15 p.m., Resident E's family indicated she did not get any updates from the facility. In mid-November, she only knew there was COVID in the building because she showed up to visit and was told she could not because of an outbreak. She had received 2 emails about the COVID-19 status on 12/21/21 and 12/27/21. She was told the emails would be weekly, but she had only received the 2 emails. On 1/26/22 at 2:09 p.m., the interim Executive Director (ED) brought a laptop in and reviewed the emails from the previous ED to families regarding COVID-19 in the facility. There were emails shown as sent weekly in December. There were no emails sent starting 1/1/22. The interim ED indicated he would get that corrected as soon as possible and would find a way to ensure during the transitions in management the communications did not stop. The interim Executive Director provided the current COVID-19 policy, updated on 1/16/22, titled, "Action Plan-COVID-19." The policy indicated, "...COMMUNITY GUIDANCE WHEN			

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	COVID-19 IS NEWLY DISCOVERED ...E. the following guidance FOR NOTIFICATION is applicable if there is a confirmed case of COVID-19 as described above: 1. Verbal communication immediately to the following ...Resident Representative ...All Resident Representatives will be notified verbally by 5 P.M. the next calendar day of the positive notification of confirmed COVID-19 or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other ...Written notification will also be sent to Resident Representatives ...Updates will be provided to Residents and Resident Representatives weekly if no new cases or suspected cases occurred that week of by 5 P.M. the next calendar day following the subsequent occurrence of either a confirmed infection of COVID-19 is identified and/or whenever 3 or more residents or staff with new onset of respiratory symptoms occurs within 72 hours ...Notifications will include the following ...Cumulative total of confirmed cases ...Information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations in the nursing home will be altered ...." This State Residential Finding relates to Complaints IN00371573 and IN00371581.			
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation and interview, the facility	R 0154	Preparation and submission of	02/25/2022

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	failed to ensure kitchen supplies were stored off the floor and, in a manner, to avoid possible contamination for 2 of 2 days of observation. Findings include: On 1/25/22 at 1:37 p.m., the Assistant Kitchen Manager indicated they had an empty apartment as a storage room previously, but it had been rented out so now extra supplies were kept throughout the kitchen and in the hallway. This was not working out since people keep getting into the boxes and paper products were stored in boxes on floor. On 1/25/22 at 2:10 p.m., 2:50 p.m., and on 1/26/22 at 12:42 p.m., the following kitchen supplies were observed stored in boxes on the floor in the access hallway between the kitchen and the locked memory care unit: Disposable plastic containers - 4 boxes Disposable plastic lids - 1 box Foam-hinged lid containers - 6 boxes Trash-can liners- 1 box Fungicide- 1 box Acid cleaner -1 box Blaze machine detergent -2 boxes Plastic divider plates- 1 box Dinner napkins- 1 box Insulated Styrofoam cups -3 boxes Disposable griddle polish pads- 2 boxes Large roll plastic wrap- 1 box Vinyl leaning gloves- 2 boxes Citrus scented degreaser -1 box During an interview, on 1/25/22 at 3:15 p.m., Resident E's family indicated the hall behind the kitchen, on the way back to the memory care unit, was filled with boxes on top of boxes. In order to get to the memory care unit, everyone		this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion stated on the statement of deficiencies. This statement of correction is prepared and submitted solely because of requirements under state and federal laws. We cordially request a desk review regarding the alleged deficiencies in lieu of any revisit. 1.All kitchen supplies, including overstock in service hallway, have been stored off floor on either shelves or pallets to avoid possible contamination. 1.All residents are at risk of alleged deficient practice. 1.Maintenance Director and Housekeeping Supervisor were immediately notified that supplies needed to be stored off floors. Staff education regarding storing stock/supplies off floor is scheduled for 2/21/22. 1.Maintenance Director/designee will conduct rounds of entire facility 3 times weekly for 3 months to ensure all stock/supplies are stored off floors. 1.Executive Director/Designee,	

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	had to walk past the stacked boxes. She was concerned it violated the fire codes and it was very unpleasant to have to walk back through there to visit Resident E. On 1/26/22 at 2:27 p.m., the interim Executive Director (ED) indicated there was no policy for kitchen supply storage. The facility followed the Serve Safe and the Indiana Residential kitchen regulations. Kitchen supplies should be kept 6 inches off floor and 12 inches from the ceiling. This State Residential Finding relates to Complaint IN00371581.		in collaboration with Maintenance Director/Designee will review audits with QA Committee monthly x3 months for identified issues. QA Committee will determine if audits necessitate extension past 3 months and will continue to review audit results monthly for duration of the extended timeframe as applicable. Date of completion: February 25, 2022	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation and interview, the facility failed to ensure infection control practices for COVID-19 were implemented to prevent and contain the spread of the COVID-19 virus by ensuring staff wore eye protection while providing resident care for 2 of 2 days of infection control observation, and the facility failed to report positive COVID-19 employees and residents to the Indiana Department of Health for 22 of 23 residents positive for	R 0407	1. Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion stated on the statement of deficiencies. This statement of correction is prepared and submitted solely	02/25/2022

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	COVID-19 and 3 of 5 COVID-19 positive employees. (Resident L) Findings include: 1. During a tour of the assisted living units, on 1/25/22 at 1:45 p.m., there were transmission based precaution (TBP) signs and personal protective equipment (PPE) outside the closed resident apartment doors for Residents M, H, J, L, F, G, and C. Licensed Practical Nurse (LPN) 6 and Qualified Medication Aide (QMA) 5 were observed on medication carts and assisting, within 6 feet, 2 unidentified residents without eye protection. During an interview, on 1/25/22 at 1:50 p.m., Licensed Practical Nurse 6 indicated Residents F, G, H, J, K, and L were COVID-19 positive and residing in the facility. During a tour of the locked memory care unit, on 1/25/22 at 2:10 p.m., there were 12 unidentified residents in the lounge in armchairs watching a movie. None of the residents had on masks nor were the residents socially distanced. Qualified Medication Aide (QMA) 2, Certified Nursing Assistant (CNA) 3, QMA 12, and 1 unidentified employee were observed in the dining area and lounge area around the residents with only surgical masks on. On 1/25/22 at 2:30 p.m., the Hospice Chaplain was observed to walk through the lounge and talk with 4 unidentified residents within less than 6 feet with only a surgical mask on. On 1/25/22 at 2:17 p.m, Housekeeper 10 was observed cleaning rooms on the locked memory care unit. She wore a surgical mask only. She		because of requirements under state and federal laws. We cordially request a desk review regarding the alleged deficiencies in lieu of any revisit. 1. While any COVID cases in the community, eye protection and N95 mask to be worn by all direct care givers regardless resident COVID status. Point of Care COVID results will be reported through RedCap within 24 hours of testing. 2. All residents have the potential to be affected by the deficient practice. When COVID is present in the community, all direct care staff will be educated to wear eye protection, as well as N95 masks, at all times while delivering care regardless of residents' COVID status. Additional employees will be trained to enter Point of Care testing results into RedCap so that there will be no future gaps in reporting. 3. If/when COVID cases recur in the community, walking rounds will be done daily to ensure that direct care staff are wearing eye protection and N95 masks for all cares or interactions with residents within 6 feet. The DON/designee will audit weekly for 4 weeks to ensure that RedCap reporting is being	

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	indicated she was the housekeeper for the locked memory care unit and then assisted on the 300 hallway on Fridays. She was observed assisting an unidentified resident to her room within 6 feet of the resident with only a surgical mask on. On 1/26/22 at 12:35 p.m., QMA 5 exited a resident's room on the100 hallway without eye protection on holding a box of unidentified medication. The resident was not on transmission based precaution. During multiple observations of the assisted living unit, on 1/26/22, no staff wore eye protection around residents in hallways or common areas. On 1/26/22 from 12:42 p.m. to 1:10 p.m., staff observed on the locked memory care unit did not wear eye protection in common areas around residents or when assisting residents in their rooms. On 1/26/22 at 12:48 p.m., Resident D's chair alarm sounded in her room. CNA 9 entered the room at 12:49 p.m. to assist the resident wearing only a surgical mask. During an interview, on 1/26/22 at 12:55 p.m., Licensed Practical Nurse (LPN) 8 indicated she worked on the locked memory care unit regularly. It had been a week and half or 2 weeks since there was COVID-19 on the unit. Staff wore N95 and face shields when there was COVID-19 positive residents on the on unit. Otherwise, they just wore a surgical mask. On 1/26/22 at 1:01 p.m., CNA 9 and LPN 8 assisted Resident D's chair alarm in her room without eye protection.		completed within 24 hours of point of care COVID testing. 4. Systemic Changes for the PPE deficient practice were completed on January 28th. Systemic Changes for the RedCap reporting deficient practice will be completed by February 25th. 5. Executive Director/Designee, in collaboration with Director of Nursing/Designee will review audits with QA Committee monthly x3 months for identified issues. QA Committee will determine if audits necessitate extension past 3 months and will continue to review audit results monthly for duration of the extended timeframe as applicable. Date of completion: February 25, 2022	

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	On 1/26/22 at 1:04 p.m., a movie was started in the lounge for the residents. CNA 9 and CNA 3 were observed to assist 5 residents into the lounge while wearing only a surgical mask and no eye protection. During an interview, on 1/26/22 at 1:27 p.m., LPN 6 indicated when going into COVID-19 rooms she wore full PPE: gown, gloves, N95, and face shield. The PPE bins usually had gowns, gloves, and N95 masks. The nurses had their own face shields in the nurses' office that they wore into TBP rooms. She was unaware of any need for any PPE but a surgical mask in non-COVID-19 rooms. During the exit conference, on 1/26/22 at 4:26 p.m., the Director of Nursing indicated she was unaware staff should wear eye protection in the non-COVID-19 rooms or common areas near residents. Since residents had private apartments and there were no COVID-19 positive residents in the locked memory care unit, there was no need to wear eye protection except in the COVID-19 positive apartments. On 1/26/22, the interim Executive Director provided the current COVID-19 policy, updated on 1/16/22, titled, "Action Plan-COVID-19." The policy indicated, "...GENERAL COMMUNITY GUIDANCE WHEN COVID-19 IS PRESENT...D. When COVID-19 is identified in the community, all direct care staff will wear the recommended PPE (i.e., eye protection and N95 respirator or higher) for the care of the residents (contingent upon PPE availability) until no new cases have been detected in the last 14 days. E. If the level of community transmission is Substantial or High, then all direct care staff are			

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		A. BUILDING 00 B. WING	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	to wear proper eye protection (goggles or face shield)...HCP working in non-patient care areas are not required to wear eye protection with Substantial or High community transmission levels, except when i. Entering the patient care areas...iv. Unable to maintain physical distancing when around residents...." The Indiana Department of Health Infection Prevention Toolkit, updated 12/14/21, indicated healthcare providers should wear eye protection for resident care in green zones when community transmission was substantial or high. A green zone (no COVID-19 residents) required universal eye protection of a face shield or goggles that cover the top, bottom and sides of eyes with no gaps when providing care within 6 feet or less for all healthcare providers regardless of vaccination status if in a county with substantial or high county transmission. The Centers of Disease Control and Prevention (CDC) COVID-19 Tracker indicated as of 1/26/22 the facility's county of residence was in a high community transmission range. 2. On 1/26/22 at 2:05 p.m., the Director of Nursing (DON) provided a list from the Indiana Department of Health COVID-19 reporting system of all staff and residents reported as tested for COVID-19 by the facility's antigen tests from 9/24/21 to 1/26/22 with their results of positive or negative. The list stopped on 12/23/21 and then restarted on 1/12/22. On 1/12/22, there were 2 positive staff reported, the Clinical Scheduler and Employee 11. The reporting stopped on 1/12/22 and restarted on 1/26/22 with 1 resident, Resident L, reported as positive.			

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	On 1/26/22, the Assistant Director of Nursing and the Clinical Scheduler provided the list of COVID-19 positive residents and staff as of 1/25/22. The list contained 28 names with the first positive case on the list dated 12/30/21. There were 5 employees listed as positive for COVID-19 and 23 residents listed as positive for COVID-19 from 12/30/21 to 1/25/22. During an interview, on 1/26/22 at 2:05 p.m., the DON indicated due to management staff being out with COVID-19 there had been no one available with access to the reporting system to report positives which caused gaps in the reporting. The DON was unaware of any reporting system besides the system they reported the antigen testing results. The interim Executive Director provided the current COVID-19 policy, updated on 1/16/22, titled, "Action Plan-COVID-19." The policy indicated, "...COMMUNITY GUIDANCE WHEN COVID-19 IS NEWLY DISCOVERED ...E. the following guidance FOR NOTIFICATION is applicable if there is a confirmed case of COVID-19 as described above ...Local Health Department ...State Regulating Agency ...Written notification to the local health department and State regulating agency will be provided as required by the individual entity...." The "LTC Facility COVID-19 Data Submission Guidelines", updated 12/21/20, indicated, " ...the state requires that facilities report to the following systems, which are focused on patient-level testing information ...Long-term Care COVID-19 Reporting form ...COVID-19 Point of Care (POC) test reporting form ...." The "Reporting Systems for COVID-19" table included in the document indicated the			

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	Long-Term Care COVID-19 Reporting form was used to report all positive case results and submissions for staff and residents. This reporting was required for residential care facilities within 24 hours of a positive result. The COVID-19 Point of Care (POC) Test Reporting form was for POC test reporting for both positive and negative POC tests even if a false positive. This reporting was required for residential care facilities within 24 hours of a positive result. The "COVID-19 LTC Reporting Summary" table indicated Residential Care facilities that had a positive COVID-19 POC test for staff or residents had to report to the Long-term Care COVID-19 reporting form and the COVID-19 POC test reporting within 24 hours of the result. This State Residential Finding relates to Complaints IN00371573 and IN00371581.			