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	01/07/2020

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

(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
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: January 6, and 7, 2020. Facility number: 012394 Residential Census: 105 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on January 16, 2020.	R 0000	**This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of Sugar Grove Senior Living as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community**	

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

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			or affiliated companies.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure staff wore hair and beard restraints while in the kitchen, for 1 of 1 kitchen observation, and while handling food during dining for 1 of 2 dining observations in the Memory Care Unit. The facility failed to ensure an ice scoop was stored, to prevent contamination, for 1 of 2 dining observations in the Memory Care dining room which had the potential to 35 of 35 residents served meals in the Memory Care Dining Room. Findings include: 1a. On 1/6/2020 at 9:50 a.m., Dietary Aide (DA) 15 was observed in the kitchen with part of her front hair out of the hairnet. On 1/6/2020 at 9:52 a.m., Cook 20's mustache was not covered by a beard cover, as he prepared a poached egg for a resident. On 1/6/2020 at 9:53 a.m., Cook 21's mustache was not covered by the beard cover, as he prepared a large pan of pasta salad for lunch service. During an interview, on 1/6/2020 at 10:32 a.m., Cook 20 indicated, he did not know his mustaches	R 0273	273 1. DA, Cook 20, Cook 21, and CNA 15 are properly utilizing hairnets and beard restraints. The ice scoop is properly stored. 2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3. Dietary staff was in-serviced on properly utilizing hairnets, beard restraints and proper storage of ice scoops. In addition, the Dietary Manager or designee will ensure that the staff is properly wearing hairnets and beard restraints and that the ice scoops are stored properly when not in use. 4. The Executive Director or designee will randomly check dietary staff for the next 7 months to ensure compliance with hairnets, beard restraints and proper storage of ice scoops 5. Systemic change date: February 24, 2020	02/24/2020

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	should be covered. During an interview, on 1/6/2020 at 10:34 a.m., the Dietary Manager, (DM) indicated, the facility followed the Indiana State Department of Health's Retail Food Establishment Sanitation Requirements. 1b. On 1/6/2020 at 12:05 p.m., CNA 15 was observed as she prepared, and served plates of food, from large metal pans brought from the facility kitchen. She wore a hairnet on the top of her head, covering a pony tail but the back and sides of her hair were uncovered. On 1/6/2020 at 12:42 p.m., during an interview, CNA 15 indicated the hairnet should cover all of her hair, but it slid up, sometimes. She was not aware it had slid up and the back and sides of her hair were not covered. A current policy, titled, "Hair Restraint Policy," with no date, was provided by the Administrator on 1/6/20 at 1:00 p.m. A review of the policy indicated, "...It is the policy of this Community that all dietary staff shall wear hair restraints (hairnets), including beard restraints if applicable, while in the kitchen and preparing meals." 2. On 1/6/2020 at 11:50 a.m., during a dining observation, in the memory care dining room, a red cooler/ice chest with a white lid was observed on the countertop, beside the sink. A clear plastic scoop rested on the lid of the ice chest, uncovered, with the scoop touching the surface of the lid. On 1/6/19 at 12:01 p.m., Certified Nurse Aid, (CNA) 17 was observed as she passed drinks to residents in the Memory Care Dining Room. She used the ice scoop which had been lying on the			

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	lid of the ice chest. When she finished scooping ice from the ice chest she placed the scoop on top of the lid, uncovered. On 1/6/2020 at 12:40 p.m., during an interview, Licensed Practical Nurse (LPN) 16 indicated, the ice scoop was always kept on top of the ice chest. They did not place it in a bag or container, when not in use. On 1/7/2020 at 3:03 p.m., the Administrator provided a current undated policy, from the Dietary Services Operations Manual, this policy indicated, "...Scoops. Use a scoop or utensil with a handle to dispense ice or food. Do not use bowls, cups, or other items for dispensing. To store the scoop, place it so that the handle is not in contact with the ice or food..." She indicated this was the only policy which pertained to scoops. The facility followed the Indiana Retail Food Manual and State Regulations.			
R 0378 Bldg. 00	410 IAC 16.2-5-11.1(b)(1)(A-H)(2-3) Mental Health Screening- Deficiency (b) If the individual is a recipient of Medicaid or federal Supplemental Security Income (SSI), the individual needs evaluation provided in section 2(a) of this rule shall include, but not be limited to, the following: (1) Screening of the individual for major mental illness, such as a diagnosed major mental illness, is limited to the following disorders: (A) Schizophrenia. (B) Schizoaffective disorder. (C) Mood (bipolar and major depressive type) disorder. (D) Paranoid or delusional disorder. (E) Panic or other severe anxiety disorder. (F) Somatoform or paranoid disorder.			

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	(G) Personality disorder. (H) Atypical psychosis or other psychotic disorder (not otherwise specified). (2) Obtaining a history of treatment received by the individual for a major mental illness within the last two (2) years. (3) Obtaining a history of individual behavior within the last two (2) years that would be considered dangerous to facility residents, the staff, or the individual. Based on observation, interview, and record review, the facility failed to obtain a mental health screening, and a 2 year history of mental health treatments and behaviors, after they identified a major mental illness diagnoses for 1 of 1 residents reviewed with a major mental illness (Resident 23). Findings include: On 1/6/2020 at 10:00 a.m., during the facility entrance conference, the Administrator (Adm.) provided a list of residents with major mental illness. The list included Resident 23. On 1/7/2020 at 10:30 a.m., the medical record for Resident 23 was reviewed. Resident 23 was admitted to the facility on 10/5/2019. The diagnoses included, but were not limited to, Schizophrenia (a mental illness), schizoaffective disorder (a mental illness), major depression, and anxiety. The medical record did not include a mental health screening, or 2 year history of mental health treatment and behaviors. On 1/7/2020 at 3:20 p.m., Resident 23 was observed in her apartment, during a random medication pass observation. Resident 23 was	R 0378	R 378 1. The Community will obtain a mental health screening for Resident 23. 2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3. The Wellness Director or designee will review charts of residents, if any, who were identified with major mental illness to ensure they received a mental health screening. 4. The Executive Director or designee will randomly audit the charts of residents, if any, who were identified with major mental illness to ensure they received a mental health screening for the next 7 months to ensure compliance. 5. Systemic change date: February 24, 2020	02/24/2020

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	reclining on her bed, and complained of dizziness, whenever she stood up. She indicated she had called her doctor's office and was waiting for a return call. On 1/7/2020 at 11:41 a.m., during an interview, the Director of Nursing Services indicated Resident 23 was a Medicaid recipient. The resident's mental illness was managed by her family physician. She did not see a psychiatrist or psychologist. The facility did not have a mental health screening for this resident which included a history of her mental illness, or behaviors. The facility did a nursing assessment on admission, as part of the service plan, but they did not have any type of specialized mental health screening, or assessment, for residents with major mental illness. They had offered for the resident to see the psychiatric consultants, which came into the facility, but the resident did not want to see them.			
R 0382 Bldg. 00	410 IAC 16.2-5-11.1(f) Mental Health Screening - Noncompliance (f) Each resident with a major mental illness must have a comprehensive care plan that is developed within thirty (30) days after admission to the residential care facility. Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan, in cooperation with the mental health provider, for 1 of 1 residents reviewed with a major mental illness diagnosis, (Resident 23). Findings include: On 1/6/2020 at 10:00 a.m., during the facility entrance conference, the Administrator (Adm.) provided a list of residents with major mental	R 0382	R 382 1. The Community will develop a comprehensive care plan, in cooperation with the Resident 23 mental health provider. 2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3. The Wellness Director or designee will review charts of residents, if any, who were	02/24/2020

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	illness. The list included Resident 23. On 1/7/2020 at 10:30 a.m., the medical record for Resident 23 was reviewed. Resident 23 was admitted to the facility on 10/5/2019. The diagnoses included, but were not limited to, Schizophrenia (a mental illness), schizoaffective disorder (a mental illness), major depression, and anxiety. No comprehensive care plan, developed with the physician, for mental health, was documented for Resident 23's mental illness. On 1/7/2020 at 3:20 p.m., Resident 23 was observed in her apartment, during a random medication pass observation. Resident 23 was reclining on her bed, and complained of dizziness, whenever she stood up. She indicated she had called her doctor's office and was waiting for a return call. On 1/7/2020 at 11:41 a.m., during an interview, the Director of Nursing Services indicated Resident 23 was a Medicaid recipient. The resident's mental illness was managed by her family physician. She did not see a psychiatrist or psychologist. The facility did not have any care plans, which were developed in cooperation with a physician, to address the resident's major mental illness diagnoses. On 1/7/2020 at 12:52 p.m., during an interview the Adm. indicated Resident 23 had a service plan and nursing assessment which identified the care the facility provided for her. She did not have a comprehensive care plan.		identified with major mental illness to ensure they have a comprehensive care plan, in cooperation with their mental health provider. 4. The Executive Director or designee will randomly audit the charts of residents, if any, who were identified with major mental illness to ensure they have a comprehensive care plan, in cooperation with their mental health provider for the next 7 months to ensure compliance. 5. Systemic change date: February 24, 2020	