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	10/27/2021

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

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00363225 and IN00365327. Complaint IN00363225 - Substantiated. State Residential Findings related to the allegations are cited at R0148 and R0214. Complaint IN00365327 - Substantiated. State Residential Findings related to the allegations are cited at R0214. Survey date: October 26 and 27, 2021. Facility number: 012394 Residential Census: 117 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on November 4, 2021.	R 0000		
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state			

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

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	electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, interview, and record review, the facility failed to ensure a cable chord was not taped across the floor of a resident apartment to prevent the potential for falls for 2 of 5 residents reviewed for accidents, (Resident C and D). Findings include: A confidential interview during the survey, indicated there was a long black chord taped to the floor of Resident B and C's apartment. It ran the length of the living room floor in front of the TV and was a fall risk because the tape kept peeling up and the cord was loose. On 10/26/21 at 10:15 a.m., Resident B and C's room was observed. Resident B sat in a recliner and Resident C sat in a rocking chair. Both chairs sat on top of a large oval area rug. A long black cable cord was observed that ran the length of the living room floor, it was tucked under one edge of the area rug, but then came out from under the rug in front of the TV. The cord was taped to the floor, but the edges of the tape were frayed and rolled back. At this time, Resident B indicated it was a cable cord that hooked to the TV and had been like that for a long time. The Maintenance Director was supposed to come and re-route the cord but never had. Resident B indicated she and her spouse, just tried not to walk around that area to avoid tripping over it. On 10/27/21 at 9:53 a.m., Resident C's medical	R 0148	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. **R148—Sanitation and Safety Standards--Deficiency** (a) Cable cord has been securely taped to floor in apartment of Residents B and C. This cord will be re-routed to negate the need for taping to floor to prevent the potential for tripping by 11/22/21. (b) All residents are at risk of same alleged deficient practice. Maintenance Director/designee will inspect all AL/MC residential apartments for improperly secured cables spanning lengths of floor space and resolve any identified concerns by 11/22/21. (c) Maintenance Director has been re-educated regarding	11/22/2021

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	record was reviewed. A nursing progress note dated 6/27/21 indicated, Resident C had fallen after she tripped over her spouse's rollator walker. She was found on the bathroom floor of her apartment and complained of pain in her knee and hip. She was sent out via EMS (emergency medical service) but returned later that evening with no acute fractures. During an interview on 10/27/21 at 11:50 a.m., the Director of Nursing indicated, any resident with a previous fall was considered a fall risk. She did not believe there was a policy about what should or should not be in a resident's room, or an environmental policy. During an interview on 10/27/21 at 1:12 p.m., the Executive Director (Ed), indicated there was no policy about what should or should not be in a resident's room, but that a cord taped across the floor would be considered a fall risk and it would be removed immediately. This State Residential Finding relates to Complaint IN00363225.		identifying and resolving any potential tripping hazards on 10/28/21. Maintenance and Housekeeping personnel will be re-educated regarding identifying and resolving any potential tripping hazards by 11/22/21. (d) Maintenance Director/designee will inspect 5 residential apartments at random weekly x3 months to ensure potential tripping hazards do not exist. (e) ED/Designee will review weekly audits monthly x3 months with community management team for quality assurance. ED/Designee will determine whether weekly audits need to be extended past 3 months and will continue to review monthly thereafter, for duration of extended timeframe, for quality assurance. Date of completion: 11/22/21	
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on observation, interview and record review, the facility failed to ensure a change of	R 0214	Preparation and submission of this statement of correction does not constitute an admission or	11/22/2021

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	condition assessment was completed for a resident after a fall with injury, who was transferred from assisted living to the secured memory care unit and then experienced decreased mobility, and increased confusion for 1 of 5 residents reviewed for quality of treatment (Resident F). The facility failed to ensure neurological check assessments were implemented according to nursing standard practice for residents with unwitnessed falls (Residents E and F) for 2 of 5 residents reviewed for quality of treatment. Findings include: 1. On 10/26/21 at 12:56 p.m., Resident F's record was reviewed. The most recent assessment was an Admission evaluation dated 5/12/21. The assessment indicated Resident F was alert to person, place, and time, and was cognitively intact. She had experienced falls within the prior 90 days, but none with injury and they were due to age related decline. There were no fall prevention interventions selected. An admission fall risk assessment was dated 5/12/21, and indicated Resident F was a high fall risk. A nursing progress note dated 10/10/21 indicated, Resident F fell that day around 4:00 p.m., in the front lobby reception area. She was found lying on her back and sustained several small bruises and skin tears to her right hand and had a small abrasion to the left side of her face. A follow up incident report, dated 10/10/21, indicated a Qualified Medication Aide (QMA) found Resident F laying on her back at the front reception area calling out for help. Resident stated		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. **R214—Evaluation--Deficiency** The resident that was found not to have had a Change of Condition Evaluation completed now has a Change of Condition Evaluation completed as of 11/12/21 in the resident medical record. (b) All residents who have recently moved from Assisted Living to Memory Care, had a recent fall, and/or who have contracted with hospice services recently are at risk of the same alleged deficient practice. An audit of resident records for Condition Change Evaluation will be completed by DON/Designee for all residents who have made a move from Assisted Living to Memory Care in the past 3 months, all residents who have experienced a fall in the past 3 months, and all residents who have contracted with hospice services in the past 3 months by 11/22/21. This will identify any	

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	she hit her head. She sustained small abrasions on her right knee and 3 small abrasions to her right hand, and a small abrasion on the right side of her face. Outcomes of the fall indicated she was moved to memory care, and the family declined physical or occupational therapy and requested hospice to evaluate her. A document titled, "Head Injury Monitoring Tool," dated 10/10/21, indicated Resident F was checked once every shift after the fall. A provider progress note, dated 10/21/21, indicated Resident F was being seen as the request of the nursing staff for physical decline and pain. Per staff Resident F was extremely anxious most of the time. She was currently on Zoloft (an antidepressant medication) 100 milligrams (mg) daily. Staff did not note that when her as needed (PRN) lorazepam (anti-anxiety medication) was given, she would fall asleep and then would be calm for a couple hours. They noted that family did not want Resident F to take the lorazepam because they thought it was too strong. Additionally, her family noted that she complained of right arm pain. An X-ray was obtained and revealed no fractures. Staff reported the resident only complained pain when family was present. Family also state that she had gotten increasingly weaker since moving to memory care. During an interview on 10/27/21 at 10:42 a.m., the Director of Nursing (DON) indicated Resident F had experienced a decline in her health. She had moved twice in the last year, initially into assisted living, then into memory care. The move to memory care had already been discussed at the time of the fall on 10/10 and since her move she had an increase in confusion and decline in mobility. A change of condition assessment		residents who should have had a Change in Condition Assessment completed. Any residents found to necessitate a Condition Change Evaluation that was not previously completed will be completed at this time. (c) Education regarding Indiana State Department of Health Residential Care regulations concerning Evaluation of a Resident was provided to the new Director of Nursing as well as company policy regarding the same on 10/28/21. (d) The DON/Designee will complete a review once weekly x3 months of residents who have fallen, residents with cognitive changes, and residents with an emerging need for a higher level of care to further determine if a Change in Condition evaluation needs to be completed. (e) DON/Designee will review weekly audits monthly x3 months with community management team for quality assurance. ED/DON/Management will determine whether weekly audits need to be extended past 3 months and will continue to review monthly thereafter, for duration of extended timeframe, for quality assurance. Date of completion: 11/22/21	

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	should have been completed On 10/26/21 at 2:10 p.m., Resident F was observed in her memory care apartment. She sat up in a recliner chair, with a blanket over her lap. Resident F's facial expression was worried, and her voice was shaky and high pitched. She indicated she wanted to go sit in her chair, even though she was already in her chair. She indicated no one had given her any food, but at lunch she was told to try and eat as much as she could, so she could go sit back in her room. The longer she spoke, the more upset she became, and her eyes watered with tears, and she indicated she wanted to get up. CNA 5 entered the room and told Resident F she was there to help her go to the bathroom. When CNA 5 assisted Resident F to stand the resident called out, "Oh God, please don't let me fall!" CNA 5 assured her she would not fall. Resident F struggled to stand, did not stand up straight, and shuffled when she walked with her rollator walker. When CNA 5 got Resident F to the bathroom, another (unidentified) resident entered Resident F's doorway, and CNA 5 let go of Resident F to redirect the other resident out. When CNA 5 let go, Resident F screamed out, "Oh God! I'm going to fall!" CNA 5 reached her arm back out to Resident F and assured her again, that it was "ok", and she would not fall. During an interview on 10/27/21 at 9:22 a.m., Licensed Practical Nurse (LPN) 4 indicated nursing staff would know who was a fall risk and what interventions should be in place based off the CNA assignment sheet. At this she provided a copy of the memory care CNA assignment sheet, and it was reviewed at this time. Resident E's CNA assignment indicated she should be assisted to use the bathroom every 2 hours, and "...anxious, emotionally unstable, walker..." The assignment			

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	sheet did not indicate she was a high fall risk. During an interview on 10/26/21 at 2:20 p.m., CNA 5 indicated, Resident F was new to memory care, and very anxious. She was always afraid she might fall. She was pretty confused and did not know where she was. 2. On 10/26/21 at 11:38 a.m., Resident E's medical record was reviewed. A Service Plan dated 3/8/21 indicated Resident E had fall within the last 90 days, usually occurred in the evening and were due to acute illness, age related decline in function and unsafe behaviors of getting up from her wheelchair to clean. Interventions that were put into place after each fall listed: On 3/31/21, her wheelchair was to be locked and next to resident's bed. On 4/2/21, it was recommended to involve resident in activities. A nursing progress note dated 10/3/21 indicated Resident E fell back while in her wheelchair around 4:00 p.m., in the dining room. After the fall, Resident E complained of pain in her head and back. An Incident Report, dated 10/3/21, indicated Resident E had an unwitnessed fall. She fell on her back side while in her wheelchair. She complained of pain in her head and neck, but no bumps/redness were noted. Family notified and daughter came to visit. Family declined transfer to the emergency room. Outcome of the investigation indicated, it was believed, Resident E pushed off from the table and fell backwards, so anti-tippers were recommended to be placed on her wheelchair, and Hospice would order them. A document titled, "Head Injury Monitoring			

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	Tool" dated 10/3/21 indicated, Resident E was checked once every shift after the fall. The record lacked documentation of a new order for anti-tippers to be placed. On 10/26/21 at 1:50 p.m., Resident E was observed in her memory care apartment room with a family visitor. No anti-tippers were observed in place on the wheelchair the resident sat in. At this time, the family member indicated she had been made aware of the fall on 10/3 and she came right out to visit. Resident E was confused, but not due to the fall, she had a UTI. After that fall they were supposed to have put anti-tippers on the wheelchair, but the family member never heard anything else about them. On 9/27/21 at 9:20 a.m., Resident E was observed lying in bed with her eyes closed. A fall mat was placed on the floor to the open side of her bed, but her wheelchair was in front of her closet, out of reach of the mat. During an interview on 10/27/21 at 9:22 a.m., LPN 4 indicated nursing staff would know who was a fall risk and what interventions should be in place based off the CNA assignment sheet. At this she provided a copy of the memory care CNA assignment sheet, and it was reviewed at this time. Resident E's CNA assignment indicated she should be assisted to use the bathroom every 2 hours, and "...Hospice, wheelchair, bed alarm, daughter comes often..." The assignment sheet did not indicate she was a high fall risk. During an interview on 10/27/21 at 10:41 a.m., the DON indicated, Resident E's unwitnessed fall happened in the dining room after she pushed off from the table and fell back in her wheelchair.			

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	Anti-tippers had been recommended and it was her expectation that any new fall interventions should be put into place within 72 hours. During the survey exit conference on 10/27/21 at 1:30 p.m., the DON indicated she followed up with Resident E's family member and they had refused the offer to put anti-tippers on the wheelchair. A corresponding nursing progress note was provided at this time and indicated, on 10/27/21 at 11:30 a.m., the DON contacted Resident E's family member and she refused the anti-tippers because they would cause her to trip. During an interview on 10/27/21 at 11:50 a.m., the DON indicated the facility fall policy indicated if a resident had an unwitnessed fall, or any fall with obvious head injury, staff should always initiate neurological (neuro) checks. Neuro checks were important to determine if any underlying injuries had occurred that sometimes developed after a resident fall. The neuro check assessments included but may not be limited to, checking the resident's vital signs, pupil dilation and reaction, range of motion. At this time, she provided a copy of the blank tool, titled, "Head Injury Monitoring Tool" and indicated it only required nursing staff to assess the resident on every shift for 9 shifts. During an interview on 10/27/21 at 12:56 p.m., the DON provided a copies of current facility policies. At this time, she indicated, the neuro check assessments were not being completed according to the new facility policy. Apparently when the new management company took over, nursing staff continued to use the old tool which only required residents be assessed every shift for 72 hours following a fall, but the new policy followed the nursing standard practice to assess the resident every 15 minutes for the first hour after a			

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	fall, every hour for 4 hours after the fall, and then every shift for the remainder of the follow up timeframe. The first policy was titled, "Fall Policy," dated 9/17/19. The policy indicated, "The purpose of the Fall Management Program is to develop, implement, and evaluate an interdisciplinary team falls prevention approach and manage strategies and interventions that foster resident independence and quality of life... Residents found to be at high risk for falls are placed on the Fall Management Program, and interventions are implemented to meet individual needs... following any falls, the facility staff completed an Occurrence Report. Details of the fall will be recorded and potential causal factors identified and investigated. Interventions will be implemented, and care plan updated...." The second policy was titled, "Neurological Assessment," dated 2/2021. The policy indicated, " ...Neurological assessments will be completed...following an unwitnessed fall... neurological assessments (neuro checks) will be done every 15 minutes for the first hour, then every 30 minutes for an hour, then every 4 hours, then every 8 hours for a total of 72 hours...." This State Residential Finding relates to Complaints IN00363225 and IN00365327.			