STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155254	A. BUILDING _____ B. WING _____	**07/01/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a care plan for aggressive behaviors for 1 of 3 residents reviewed for possible abuse. (Resident C) Findings include: The clinical record of Resident C was reviewed on 6-29-2020 at 2:48 p.m. Her [DIAGNOSES REDACTED]. Review of her most recent Minimum Data Set (MDS) assessment, dated 6-12-20, indicated she is cognitively intact, is able to understand and to be understood, is independently ambulatory and has mood indicators for depression, tiredness and feeling bad about herself. Review of her care plans failed to identify any care plans for aggressive behaviors. In an interview with the Executive Director (ED) on 6-29-2020 at 4:25 p.m., indicated on 6-2-20 there was an incident of a verbal altercation involving Resident C and Resident D. The ED clarified the incident involved verbal insults back and forth. He added Resident C was involved in an incident in mid-May of 2020 in which Resident C was verbally aggressive towards some of the staff. In interview with the Social Services Designee (SSD) on 6-30-2020 at 3:15 p.m., she indicated Resident C had some on-going behaviors, prior to 6-2-20 with Resident D. The CNA's had told her they had seen Resident C and D arguing and Resident C told Resident D she would do it again, while out smoking. I felt like she might instigate more things and did not want this to happen. I spoke with (name of the ED) and the nurse spoke with (name of the medical director) who ordered for her to be sent out. She was sent to an area psychiatric facility on 6-2-2020 and returned on 6-11-20. It was brought to my attention yesterday that she did not have a care plan for verbal and/or physical aggression, but I did add that. In an interview on 6-30-2020 at 12:22 p.m., with RN 3, she indicated Resident C receives psychotherapy services from an outside agency. RN 3 description of Resident C included (she) just kind of loses it and can be verbally [MEDICAL CONDITION] will yell at people and say they just don't know. She added she is aware Resident C has made false allegations about staff and other residents. On 7-1-2020 at 11:15 a.m., the Director of Nursing provided a copy of a policy entitled, Care Planning-Interdisciplinary Team. This policy was identified as the current policy utilized by the facility and had a revision date of 9/2014. This policy indicated, It is the policy of this Facility to develop an individualized comprehensive care plan for each resident .(that) will assist staff to provide care to each resident. On 7-1-2020 at 11:15 a.m., the Director of Nursing provided a copy of a policy entitled, Care Plans - Comprehensive. This policy was identified as the current policy utilized by the facility and had a revision date of 9/2014. This policy indicated, An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident .that identifies the highest level of functioning the resident may be expected to attain .Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition changes . This Federal tag relates to Complaint IN 301. 3.1-35(a) 3.1-35(b)(1)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure facial coverings (masks) were worn and/or utilized correctly by staff, visitors received screening prior to entry into the facility and appropriate social distancing occurred among residents when in common areas of the facility. This had the potential to affect all 45 residents of the facility. Findings include: An observation was conducted on 6-29-2020 at 9:20 a.m., of a masked visitor entering the facility at door 3. The visitor was granted access to the facility by a staff employee wearing a mask. At entrance, the visitor was not offered any type of handwashing or ABHR (alcohol-based hand rub), but was assisted to the closest nurse's station, 2 halls away, past multiple resident rooms and 6 unmasked residents for screening of possible infection. At the nurse's station, QMA 2 checked the visitor's temperature and asked screening questions regarding possible infection. QMA 2 and another staff member were less than 6 feet from the visitor and did not have masks in place. QMA 2's mask was hanging by the ear loop from her right ear. ABHR was not offered to the visitor. During a walking tour of the facility, from room [ROOM NUMBER] to 43, on 6-29-2020 from 11:05 a.m. to 11:08 a.m., an observation was conducted in which 9 residents were observed in the hallways without facial coverings in place. Three staff and one resident were observed in the Executive Director's (ED) office without facial coverings in place and social distancing of six feet or more was not being practiced. On 6-29-202 at 1:10 p.m., QMA 2 was observed in the hallway at a medicine cart, near the staff breakroom, wearing her mask below her nose. Two minutes later, at 1:12 p.m., QMA 2 was observed in the same location at the medicine cart with her mask below her mouth. An observation on 6-29-2020 at 1:12 p.m., was conducted of ED in hallway, near dining area, of him bent down to speak to a speak to a resident seated in a wheelchair. The ED was observed without a mask in place. The ED's face was observed within 2 feet of the resident's unmasked face. On 6-29-2020 at 1:55 p.m., the Assistant Director of Nursing (ADON) was observed in the hallway, near room [ROOM NUMBER], without a mask in place. She was observed to use her lab jacket lapel to cover a portion of her mouth and nose. She indicated, I lost my mask. On 6-29-2020 at 1:55 p.m., 14 residents were observed in the dining area, near an exit door to the outside patio. None were wearing facial coverings and social distancing was not being practiced. The Director of Nursing (DON) was overheard to address the surrounding staff, We need to move these people apart. They're too close together. Three staff, including the DON, were observed in the area at that time, each with masks in place. An observation was conducted on 6-30-2020 at 9:05 a.m., of a masked visitor entering the facility at door 3. The visitor was granted access to the facility by the ADON, wearing a mask. The visitor was offered ABHR located near the entrance. The visitor's temperature was taken, but no screening questions were posed by the ADON and the writer was allowed to continue into the building. An observation of a smoking period on the facility's patio area was conducted on 6-30-2020 at 10:03 a.m., with 10 residents and 2 staff present. Both staff members wore masks. None of the residents were observed with a mask in place during the smoking period. At one table, 3 residents were seated together and at a second table, 2 residents were seated together. The remaining 5 residents were observed seated in close proximity. None of the residents were observed [MEDICATION NAME] social distancing of six feet or more. On 7-1-2020 at 11:00 a.m., the ED provided a copy of the Indiana State Department of Health's Visitation Guidelines for Long-Term Care Facilities, with a revision date of 6-29-2020. The ED indicated, These (guidelines) came out on 6-29-2020. These are our most current guidelines. This document indicated, Precautions and restrictions put in place at long-term care facilities to mitigate the spread of COVID-19 and protect residents should be balanced against residents' need for increased socialization and visitation and their physical and mental well-being .Continued universal mask use by all staff (medical grade masks) and visitors (cloth is acceptable). Residents to wear mask (cloth is acceptable) when they leave their rooms, as tolerated, unless otherwise outlined below. Continue to maintain social distancing of at least six (6) feet between residents and staff as much as possible .Continue visitor screening and temperature checks; do not permit entry if symptoms are present .Adherence to strict hand hygiene should continue for all, particularly staff, including when entering the facility

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) .Visitors shall participate in and pass a symptom screening and temperature check. Facilities shall also require visitors to sign in and attest to there current COVID-status and symptoms. A log should be taken of visits, which should include name, contact information and start and end time of visit. (Visitors shall) wash their hands or utilize an alcohol-based hand rub upon arriving at the facility .Staff shall educate (visitors) on proper PPE (personal protective equipment) use and visitation policies. (Staff shall) ensure residents wear a mask when visitors are present . How to Put On (Don) PPE Gear, was retrieved from the www.cdc.gov/coronavirus/2019 website on 7-2-20. This information was updated on 6-11-20. It indicated, .Respirator/facemask should be extended under the chin. Both your mouth and nose should be protected. Do not wear the respirator/facemask under your chin .If mask has loops, hook them appropriately around your ears . This Federal tag relates to Complaint IN 360 and the COVID-19 Focused Survey. 3.1-18(b)