

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/21/2026
NAME OF PROVIDER OR SUPPLIER SUNRISE ON OLD MERIDIAN		STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDIAN ST, CARMEL, , 46032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intake 470889 and 471006. Intake 470889-State deficiencies related to the allegations are cited at R52. Intake 471006-State deficiencies related to the allegations are cited at R52. Survey date: July 21, 2026 Facility number: 012141 Residential Census: 80 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on July 24, 2026.	R 0000			
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6)	R 0052	A. Immediate Solution: With respect to the specific	08/26/2026	

(v) Residents have the right to be free from:

- (1) sexual abuse;
- (2) physical abuse;
- (3) mental abuse;
- (4) corporal punishment;
- (5) neglect; and
- (6) involuntary seclusion.

Based on interview and record review, the facility failed to protect a resident's right to be free from abuse of a staff member for 1 of 3 residents reviewed for abuse. (Resident B) This deficient practice resulted in Resident B being admitted to the hospital for surgical repair of a broken hip.

Findings include:

During an interview, on 7/22/26 at 10:28 a.m., Resident B's daughter indicated the facility had told her Resident B was collecting used cups from the medication cart's trash when a staff member took them away from her. Resident B got upset and tried to get the cups back and ended up falling on the floor. Her brother went to the hospital and discovered the resident had a laceration on her head and a broken hip which required surgical repair. The doctor told the family the

resident/situation cited Team Member CNA 3 was terminated from her position at Sunrise.
Completed on 07/16/26.

Resident B is currently out of the community and is at a facility for rehabilitation.

B. Expand Scope: With respect to how the facility will identify residents/situations for the identified concerns

Memory Care Coordinator and the Lead Wellness Nurse interviewed other current residents that were provided care by Team Member CNA 3 to confirm that no further residents had been affected. Completed 07/15/26.

C. Systemic Change: With respect to what systemic measures have been put into place to address the stated concern

The Executive Director and Leadership Team reviewed the abuse and neglect and resident rights policy. The Regional Director of Memory Care re-trained our current team members on the appropriate approach to support residents when they are exhibiting a behavioral expression, actively engaging with the residents in a positive and dignified manner.

resident had been pushed by a staff member, causing the fall and hip fracture. After the facility had conducted their investigation, the unit manager had called her and indicated a staff member had pushed her mom and caused the fall. The staff member had been terminated.

The clinical record for Resident B was reviewed on 7/21/26 at 10:35 a.m. The diagnoses included, but were not limited to, intracapsular fracture of the right femur, depression, and dementia without behavioral disturbance.

A facility service plan, dated as last revised on 7/2/26, indicated Resident B's memory and cognition was moderately impaired and required cues, reorientation, supervision, or assistance as needed.

A facility resident evaluation, dated 7/6/26, indicated Resident B had advanced dementia and required a walker to assist with ambulation.

A facility communication note, dated 7/14/26 at 9:00 p.m., indicated Resident B's daughter was notified the resident was sent out to the emergency room due to an event which had taken place.

A facility witness statement,

This re-training of the team members will continue with the Executive Director/Leadership Team/designee. Completed by 08/26/26.

D. Monitoring: With respect to how the plan of correction will be monitored

Coordinators/designees are responsible for compliance with the plan of correction by conducting random weekly check-ins with residents to ensure that our team members are meeting their care needs in a positive and dignified manner. We will conduct these check-ins for the next 180 days. The results of weekly audits will be sent to the QAPI committee for review.

The Executive Director will report on compliance with the plan of correction during the Quality Assurance and Performance Improvement meeting and is responsible for implementing retraining or corrective action as needed to ensure ongoing compliance

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OMB NO. 0938-0391

dated 7/14/26, signed by CNA 4 indicated she witnessed CNA 3 push the resident away and the resident fell.

A progress note, dated 7/15/26 at 10:59 a.m., indicated the hospital stated Resident B had been admitted for a femoral neck fracture injury and was having surgery to repair the hip fracture.

During an interview, on 7/21/26 at 12:45 p.m., CNA 2 indicated she witnessed the incident. On 7/14/26, she was exiting another resident's room when she saw Resident B with a stack of water cups from the medication cart. CNA 3 grabbed the cups from the resident and added them to the trash CNA 3 was collecting. CNA 3 told Resident B to move out of the way. Resident B went to grab the trash back and hit CNA 3 on the shoulder. CNA 3 told the resident to move again and pushed her away. The resident fell, yelled out in pain, and said "you're trying to kill me". CNA 2 saw blood on the resident's head and Resident B was crying and complaining of pain. CNA 4 was there as well and had tried to catch the resident but was not close enough. CNA 3 walked away from Resident B and continued to collect trash. CNA 3 did not attempt to help Resident B or apologize. CNA 4

stayed with the resident while CNA 2 ran to get the nurse. The nurse called 911 and Resident B was transported to the hospital. CNA 3 did not help with getting assistance for Resident B at all.

During an interview, on 7/21/26 at 11:45 a.m. the Executive Director (ED) indicated CNA 3 was terminated due to pushing Resident B in front of 2 witnesses. Resident B was currently out of the facility from the injury and had surgery to repair her hip fracture.

A performance counseling & improvement plan, dated 7/15/26, indicated CNA 3 had an interaction with Resident B which led to a fall and the resident was admitted to the hospital, on 7/14/26 in the evening. CNA 3 was terminated.

A current facility policy, titled "Abuse, Neglect, & Exploitation-Prevention, Reporting and Investigation," dated 4/24/25 and provided by the ED on 7/21/26 at 10:10 a.m., indicated "...Team Members must not engage in ...abuse...of any resident ...Residents are treated with courtesy, respect, and consideration ...Definitions ...Abuse: the infliction of injury ...intimidation or punishment with resulting physical harm, pain or mental anguish"

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	This citation relates to Intakes 470889 and 471006.			
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURETerona Long	TITLEExecutive Director	(X6) DATE08/04/2026
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