

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 04/30/2025
NAME OF PROVIDER OR SUPPLIER SUGAR FORK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 1745 EAST 67TH STREET, ANDERSON, , 46013			
(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 Complaints IN00457930, IN00455654, and IN00454049. Complaint IN00457930 - State deficiencies related to the allegations are cited at R0052. Complaint IN00455654 - No State Residential Findings related to the allegations were cited. Complaint IN00454049 - No State Residential Findings related to the allegations were cited. Survey dates: April 28, 29 and 30, 2025 Facility number: 014080 Residential Census: 101 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed April	R 0000	This Plan of Correction is submitted under regulations applicable to long-term care providers. This Plan of Correction is not to be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies. The preparation/ submission and/or execution of this Plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any deficiencies are correctly applied. Submission of this Plan is evidence of compliance.		

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	30, 2025			
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (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 record review, observation and interview the facility failed to provide adequate supervision to prevent the elopement from the facility of a cognitively impaired resident living on the secured unit. (Resident B). Findings include: The clinical record for Resident B was reviewed on 4/28/25 at 11:51 a.m. Diagnoses included dementia, atrial fibrillation, macular degeneration, muscle weakness, and repeated falls. A BIMS (Brief Interview for Mental Status), dated 10/20/24, indicated the resident had severe cognitive impairment.	R 0052	Resident B received a wander assessment, and updated BIMS completed on 4/21/2025. The residents service has been reviewed and updated with interventions to engage Resident B with activities of her liking on 5/15/2025. Team Members CNA1 and CNA2 received written disciplinary action on 4/23/2025. The community's Director of Health and Wellness, or their designee, shall complete an in-service utilizing the community's Elopement Preparedness guideline for the community's current Team Members no later than 6/15/2025. Completion of such in-service shall be documented on an Inservice Attendance Record and maintained with the community's training files. New Team Members will receive Elopement Preparedness training as part of their onboarding process by the Director of Health and Wellness and or designee on day 2 of their new hire orientation. The new team members completion	06/15/2025

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A progress note, dated 4/17/25 at 2:05 p.m., indicated Resident B was seen during medication administration at 1:03 p.m. At 1:08 p.m. the Activity Director entered the memory care unit with the resident and stated she had found the resident outside the front door of the facility.

On 4/29/25 at 11:25 a.m., a security video for 4/17/25 was reviewed with the Director of Facilities. At approximately 1:05 p.m., Resident B was seen walking towards the door of the secured memory care (MC) unit. The resident was ambulating with a rolling walker. The secured door was opened by CNA 1 who was talking to CNA 2. The CNAs were standing on the skilled side of the door. The resident was observed waking between the 2 CNAs and leaving the secured unit. At 1:05:26 p.m., an unknown staff member enters the secured unit while the door remained open. The resident could be seen walking past the dining room on the unsecured part of the facility, moving towards the front lobby. At 1:06:10 p.m., the resident was seen in the front lobby. At 1:06:30 p.m., CNA 1 and CNA 2 were seen entering the secured unit and the secured door closed. At 1:06:21 p.m., the resident was seen walking past the front exit door. The door opened due to the motion sensors and the resident

of such orientation shall be documented on a certificate of completion and maintained with the community training files.

Elopement Drills shall be completed by the community's Director of Facilities, or their designee, with the community's Director of Health and Wellness, or their designee, on each shift by 6/15/2025 and then for the next 3 months on each shift and then quarterly on rotating shifts, thereafter. Completion of such drills shall be documented on an Inservice Attendance Record and maintained with the community's training files

Current Team Members have been assigned Managing Elopement and Understanding Wandering and Elopement within Relias LMS to be completed by 06/15/2025. Team Members who have not completed assigned training shall be removed from the schedule until satisfactory completion. Completion of such training shall be evidenced by a certificate for each course to be maintained within the Team Member's hard copy and/or electronic personnel file.

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exited the facility. At 1:10:02 p.m., the Activity Director was seen entering the facility through the front lobby door with the resident. At 1:11:34 p.m., the resident returned, with the Activity Director, to the secured unit. The resident was without supervision for approximately 4 minutes.

During an interview on 4/29/25 at 9:36 a.m., CNA 2 indicated on 4/17/25, as she went to the secured unit to see CNA 1. CNA 2 indicated CNA 1 was holding the door open. CNA 2 indicated she did not see the resident walk between her and CNA 1. CNA 2 indicated she did not realize the situation until the Administrator told her they had let the resident off the secured unit.

During an interview on 4.29/25 at 1:07 p.m., CNA 1 indicated she was coming off the MC unit and her coworkers were coming onto the unit. The door was held open and the resident walked off the unit. CNA 1 indicated she had not seen the resident leave the unit. After she watched the video she realized what had happened.

During an interview on 4/29/25 at 1:14 p.m., the Resident Experience Director indicated on 4/17/25 at 1:10 p.m. she was bringing the facility bus back to the facility. She saw the resident

New team members will be assigned Managing Elopement and Understanding Wandering and Elopement within Relias LMS to be completed within the first 30 days of employment. Completion of the new hire training shall be evidenced by a certificate for each course to be maintained within the Team Member's hard copy and/or electronic personnel file.

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wandering around in a circle. The resident was off the sidewalk and was standing on the circle part of the drive. She thought the resident's daughter was there to pick the resident up. The resident had her walker with her. The Resident Experience Director asked the resident what she was doing. The resident was very confused and frightened and said she did not know what she was doing. She took the resident back to the MC unit. The staff on the MC unit had not been aware the resident had been missing.

During an interview on 4/28/25 at 12:57 p.m., the Administrator indicated it was not appropriate for staff or anyone to hold the door open on the secured unit.

A current policy, dated 3/22/24, titled "Elopement Preparedness" was provided by the DON on 4/29/25 at 10:31 a.m. The policy indicated the following:

".... Program Interpretation and Implementation

ESL [Experience Senior Living] identifies an elopement as an event in which an unassisted resident crosses any threshold of which they are categorized as being unable to leave unassisted. An example of this is a Memory Care resident who exits the secured Memory Care environment without

accompaniment."

No further information was provided.

This citation relates to complaint IN00457930.

Based on record review, observation and interview the facility failed to provide adequate supervision to prevent the elopement from the facility of a cognitively impaired resident living on the secured unit. (Resident B).

Findings include:

The clinical record for Resident B was reviewed on 4/28/25 at 11:51 a.m. Diagnoses included dementia, atrial fibrillation, macular degeneration, muscle weakness, and repeated falls.

A BIMS (Brief Interview for Mental Status), dated 10/20/24, indicated the resident had severe cognitive impairment.

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Facilities. At approximately 1:05 p.m., Resident B was seen walking towards the door of the secured memory care (MC) unit. The resident was ambulating with a rolling walker. The secured door was opened by CNA 1 who was talking to CNA 2. The CNAs were standing on the skilled side of the door. The resident was observed waking between the 2 CNAs and leaving the secured unit. At 1:05:26 p.m., an unknown staff member enters the secured unit while the door remained open. The resident could be seen walking past the dining room on the unsecured part of the facility, moving towards the front lobby. At 1:06:10 p.m., the resident was seen in the front lobby. At 1:06:30 p.m., CNA 1 and CNA 2 were seen entering the secured unit and the secured door closed. At 1:06:21 p.m., the resident was seen walking past the front exit door. The door opened due to the motion sensors and the resident exited the facility. At 1:10:02 p.m., the Activity Director was seen entering the facility through the front lobby door with the resident. At 1:11:34 p.m., the resident returned, with the Activity Director, to the secured unit. The resident was without supervision for approximately 4 minutes.

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FORM APPROVED

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OMB NO. 0938-0391

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No further information was provided.

This citation relates to complaint IN00457930.

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
SIGNATURE

TITLE

(X6) DATE