

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 08/31/2026	
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 Intakes 471084 and 471470. Intake 471084 - No deficiencies related to the allegations are cited. Intake 471470 - State deficiencies related to the allegations are cited at R217. Unrelated deficiencies are cited. Survey dates: August 28 and August 31, 2026 Facility number: 014080 Residential Census: 83 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed September 11, 2026.	R 0000					

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R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on observation, interview, and record review, the facility failed to administer morning medications as ordered by the physician for 3 of 4 residents reviewed for medication administration in the	R 0117		09/16/2026
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memory care unit. This deficient practice had the potential to affect 32 residents located in the memory care unit. (Resident K, Resident L, and Resident M)

Findings include:

During an interview, on 8/31/26 at 9:45 a.m., CNA 7 indicated there was not a QMA or a nurse in the memory care unit and that she had reached out to the DON at approximately 8:30 a.m. to let her know that no one had shown up. She was told that there was agency staff coming in.

During an interview, on 8/31/26 at 10:02 a.m., the Memory Care Coordinator indicated she was not told an exact time when agency staff would arrive. She was not a QMA nor a nurse, she had a social service background and could not provide direct care.

During an interview, on 8/31/26 at 10:18 a.m., with the front desk staff member and Housekeeper 12, a person approached the desk and indicated that she was from a staffing agency. Housekeeper 12 escorted her to the memory care unit.

During an interview, on 8/31/26 at 10:21 a.m., the DON indicated she was working on staff calling in. They were using

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a staffing agency and trying to get staff in the positions and disciplining staff who called in. When she arrived at the facility, she thought a QMA was already on the memory care unit.

Resident K's Medication Administration Record (MAR) was reviewed on 8/31/26 at 1:19 a.m. and indicated a scheduled fingerstick blood sugar check was not completed and 18 units of glargine (long acting insulin) was not administered.

Resident M's MAR was reviewed on 8/31/26 at 1:21 p.m. and indicated diltiazem (treat high blood pressure) 120 milligram (mg), docusate sodium (treat constipation) 100 mg, duloxetine (treat depression) 30 mg, Jardiance (treat diabetes) 25 mg, levothyroxine (treat hypothyroidism) 100 micrograms (mcg), metformin (treat diabetes) 100 mg, omeprazole (treat acid reflux) 20 mg, acetaminophen (pain reliever) 500 mg, calcium citrate (supplement) 600 mg, Certa-vite senior (multivitamin), cetirizine (treat allergies) 10 mg, Eliquis (blood thinner) 2.5 mg, Lantus (long acting insulin) 13 units, mirabegron (treat overactive bladder) 50 mg, Ocu-vite (supplement), turmeric (supplement) 1500 mg, vitamin

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B-12 (supplement) 1000 mcg, and vitamin D3 (supplement) 1000 International Unit (IU) were not administered and the Libre sensor for blood sugars was not read.

Resident L's MAR was reviewed on 8/31/26 at 1:24 p.m. and indicated aspirin 81 mg, lisinopril (treat high blood pressure) 5 mg, acetaminophen 500 mg, pregabalin (treat pain) 25 mg, and risperidone (treat psychosis) 0.5 mg were not administered.

During a follow up interview, on 8/31/26 at 1:41 p.m., the DON indicated she was notified last night that a facility QMA called in for 8/31/26 on day shift, so she contacted regional support and regional support contacted the staffing agency. The DON did not know the agency QMA was going to be late. The QMA called the facility to let them know that she was going to be late, but they were supposed to call the DON. No one noticed in memory care that medications were not being administered. The third shift QMA left at the end of her shift and did not complete a narcotic count with anyone. The DON arrived at the facility at 9:00 a.m.

During an interview, on 8/31/26 at 1:53 p.m., Agency QMA 21 indicated she received a

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	notification last night that a shift was needed at the facility for a QMA. At 8:00 a.m., that shift had been taken, then around 9:00 a.m. she was notified that another shift for a QMA was available, so she accepted the shift but called the facility to let them know that she was going to be late as she was coming from the Indianapolis area. A current facility policy, titled "Medication Management," revised 8/11/23 and provided by the DON on 8/31/26 at 2:05 p.m., indicated the following: "...Guideline Interpretation and Implementation 1. Assistance with medications can include any or all the following: a. Administering medication directly to resident at the time the medication is to be taken per the Resident's physician order...d. Administration of medication by qualified or licensed personnel...."			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be	R 0217		09/16/2026

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appropriate to the:

- (A) scope;
- (B) frequency;
- (C) need; and
- (D) preference;

of the resident.

(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.

(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.

(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.

(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.

Based on observation, interview, and record review, the facility failed to ensure staff provided care to residents according to the resident's plan

of care for 3 of 5 personal hygiene observations. (Resident H, Resident B, and Resident J)

Findings include:

During a bed check observation, on 8/28/26 at 6:08 a.m., CNA 3 obtained incontinence wipes and an incontinence brief for Resident H. CNA 3 and QMA 11 applied gloves, removed Resident H's blankets, unfastened her brief, and CNA 3 performed peri care. They turned the resident to her left side, CNA 3 removed the soiled brief from under the resident and placed the soiled brief behind the resident near her shoulders on the incontinence bed pad. CNA 3 wiped the resident's buttocks and without changing or removing her gloves, she took the clean incontinence brief and placed it under the resident. They turned the resident to her back, QMA 11 pulled her brief up in front and secured the brief. CNA 3 placed the brief in the resident's trash can. While CNA 3 and QMA 11 used the incontinence bed pad to pull the resident up in bed, the fitted sheet came off the bolstered mattress. CNA 3 secured the fitted sheet to the bolster of the mattress and then covered the resident with the blankets. She retrieved a trash bag from her pocket, placed the soiled brief from the trash can

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	into the trash bag, CNA 3 and QMA 11 removed their gloves and performed hand hygiene. Resident H's clinical record was reviewed on 8/31/26 at 12:10 p.m., Diagnoses included bacteremia, overactive bladder, and urinary tract infection. A 6/14/26 service plan indicated she was incontinent of bowel and bladder and required reminders for incontinence care. She required one person assistance with dressing, undressing and hands-on assistance with hair care, washing her face and oral care. During a bed check observation, on 8/28/26 at 6:19 a.m., CNA 3 and QMA 11 applied gloves. They removed the blankets from Resident B and unfastened his brief. CNA 3 obtained foam peri wash and began squirting the peri wash directly on Resident B's genitals, indicating that the peri wash was going to be cold. CNA 3 cleansed Resident B's peri area and penis, QMA 11 indicated that the resident recently had a procedure completed on his penis. With her soiled gloves, CNA 3 retrieved a jar of petroleum jelly from the resident's TV stand, removed the lid and used her soiled gloved hand to remove petroleum jelly from the jar and placed it on the resident's penis.			
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	She replaced the lid onto the jar and placed the jar onto the TV stand. They turned the resident to his right side, removed the soiled brief, placed it at the end of the bed, and QMA 11 cleansed his buttocks with incontinence wipes and indicated that he was having a bowel movement and CNA 3 should let day shift staff know so they could get to him right away. QMA 11 placed the dirty wipes on top of the brief at the end of the bed. With soiled gloves, CNA 3 straightened Resident B's call pendent necklace and placed it in the middle of his chest, placed his neck pillow under his head, and covered the resident with blankets. CNA 3 placed the package of wipes on the TV stand. The soiled brief was placed in a trash bag and they removed their gloves and performed hand hygiene. During an interview, at the time of the observation, QMA 11 indicated that she would normally change gloves after providing peri care. Resident B's clinical record was reviewed on 8/28/26 at 8:30 a.m. Diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, Parkinson's disease without dyskinesia, without mention of fluctuations, candidal balanitis,			
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	and need for assistance with personal care. A 1/22/26 service plan indicated he required assistance with personal hygiene, toileting, dressing and undressing. During a morning care observation in the memory care unit, on 8/28/26 at 10:19 a.m., Resident J walked from her bed to the bathroom. CNA 4 pulled her incontinence brief down and assisted her with sitting on the toilet. CNA 4 removed the resident's incontinence brief at her feet, placed it in the trash bag, replaced it with a clean brief and put a clean pair of pants and shoes on the resident. CNA 4 proceeded to remove the resident's robe, placed a shirt over the resident's head and assisted the resident with putting a sweater on. She stood the resident up, wiped her peri area and buttocks with toilet paper, then pulled her brief and pants up without removing her soiled gloves. She removed and disposed of her gloves and pulled the resident's hair from under the collar of her sweater. CNA 4 indicated when providing morning care, normally she would wash the resident. The resident did not have any towels or wash clothes, which she believed were in the laundry. The family provided the resident's wash clothes and			
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towels. She would normally change her gloves after wiping the resident with toilet paper.

Resident J's clinical record was reviewed on 8/31/26 at 12:12 p.m. Diagnoses included unspecified dementia, unspecified severity, with psychotic disturbance and altered mental status.

A 1/22/26 service plan for bathing indicated she required one person assist with transferring in/out; steadying, washing self, drying self, applying lotion. Staff to provide step-by-step instructions and cueing during the process.

During an interview, on 8/31/26 at 10:21 a.m., the DON indicated that she had been providing education, re-education and more education on simple things, and wondered if the CNAs were taught correctly in the local CNA classroom. She was taught to wash the resident's face, change their gloves, wash the upper body, change her gloves, wash the resident's peri area and change their gloves.

A 7/8/24 revised, current facility policy, titled "Basic Care Services," provided by the DON, on 8/31/26 at 2:05 p.m., indicated the following:
"Personal care shall be provided to residents in a manner

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	intended to preserve a resident's autonomy, while maintaining resident safety and well-being.... A resident's personal care needs shall be identified through the ESL Evaluation Form in accordance with the ESL Evaluation Guideline. Status checks shall be conducted at least twice daily by Team Members. These checks involve identifying the resident in their apartment or elsewhere in the community to determine if their needs are being met, and address any concerns. Basic Care Services include: Incontinence care, dressing, grooming, toileting, bathing...." This citation relates to Intake 471470.			
R 0297	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1) (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on interview and record	R 0297		09/16/2026

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review, the facility failed to ensure a resident's physician orders were confirmed by a licensed nurse to activate the orders on the Medication Administration Records (MAR) for administration for 1 of 4 residents reviewed for medication administration. (Resident E)

Findings include:

Resident E's clinical record was reviewed on 8/31/26 at 9:19 a.m. Diagnoses included type 2 diabetes mellitus with diabetic neuropathy, hypothyroidism, dysuria, displaced segmental fracture of shaft of humerus, left arm, sequela, rash and other nonspecific skin eruption, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, constipation, personal history of other venous thrombosis and embolism, pain in left foot, essential (primary) hypertension, gastro-esophageal reflux disease without esophagitis, fluid overload, hyperlipidemia, unspecified, nasal congestion, other hemoglobinopathies, chronic obstructive pulmonary disease, chronic kidney disease, bradycardia, and hypoxemia.

A nurse's note, dated 8/2/26 at 10:10 a.m., indicated the

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resident was lying flat without pillows to prop her up, and her oxygen tubing was on the floor. Her oxygen saturation was 81%. Oxygen was applied, and she was repositioned upright. She was taken to the bathroom, and her breathing did not improve, and she was unable to use her left leg as she normally did. The facility's nurse practitioner instructed to send her to the emergency room, pending family approval. All three emergency contact numbers were attempted with no reply. Emergency medical services (911) were called, and the resident was transported to a local hospital.

A nurse's note, dated 8/2/26 at 7:43 p.m., indicated she had low oxygen, urinary tract infection, and pneumonia.

A nurse's note, dated 8/27/26 at 1:30 p.m., indicated she was readmitted to the facility after a rehabilitation stay at a local skilled nursing facility.

An August 2026 medication administration record (MAR) indicated there were pending confirmations for the following medications:

Breo ellipta (improves breathing function) one puff daily (start 8/28/26),

Guaifenesin (expectorant) 400

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mg three times daily (start 8/29/26),

Ipratropium/albuterol (treat bronchospasms) inhalation solution 3 milliliters (ml) four times daily (start 8/29/26),

Quetiapine (treats psychosis) 25 mg daily (start 8/29/26), and

Valsartan (treat high blood pressure) 60 mg twice daily (start 8/29/26).

The MAR lacked documentation that the pending medications were administered.

A review of the skilled nursing facility's Transfer/Discharge Report, 8/31/26 at 11:13 a.m., provided by the DON indicated the following pending confirmation medications were last given:

Guaifenesin 400 mg three times daily last given on 8/27/26 at 8:21 a.m.

Ipratropium/albuterol inhalation solution 3 ml four times daily last given on 8/27/26 at 8:21 a.m.

Quetiapine 25 mg daily was last given on 8/26/26 at 9:51 p.m.

Valsartan 60 mg twice daily on 8/27/26 at 8:23 a.m.

During an interview, on 8/31/26

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at 11:09 a.m., the DON indicated that she was not aware there was pending medication for Resident E and that all she needed to do was confirm the pending orders. She indicated that when the nurse practitioner added new orders, he normally reached out to her to let her know. The pending orders were able to be viewed by the QMAs and sometimes they notified her that the orders were pending.

During an interview, on 8/31/26 at 11:35 a.m., QMA 13 indicated that when she noticed the pending order confirmation notation, she either notified the nurse in the facility or the DON to confirm the orders.

During an interview, on 8/31/26 at 11:52 a.m., QMA 15 indicated the pending order confirmation had to be confirmed by the facility nurse or the DON. The electronic health record system did not allow medications to be documented as given if the order was pending.

During an interview, on 8/31/26 at 2:13 p.m., the Administrator from a sister facility providing support while the facility's administrator was absent from the facility, indicated they did not have a policy related to confirming pending orders.

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FORM APPROVED

OMB NO. 0938-0391

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
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