

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 11/13/2024	
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 Complaint IN00445979. Complaint IN00445979 - State deficiency related to the allegation is cited at R0036. Survey date: November 13, 2024 Facility number: 014080 Residential Census: 97 This State Residential Findings is cited in accordance with 410 IAC 16.2-5. Quality review completed November 21, 2024.	R 0000					
R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has	R 0036	Resident B's legal representative was notified by the community's Executive Director during the 11/13/2024 complaint survey.			12/13/2024	

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noticed:

(1) a significant decline in the resident ' s physical, mental, or psychosocial status; or

(2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.

Based on interview and record review, the facility failed to notify a resident's family regarding a resident-to-resident sexual incident for 1 of 2 reviewed for abuse. (Residents B)

Findings include:

The clinical record review for Resident B was completed on 11/13/24 at 10:04 a.m. Diagnoses included dementia, psychotic disturbance, anxiety disturbance, repeated falls, restlessness, agitation, and hallucinations.

A progress note, dated 10/23/24 at 10:10 p.m., completed by QMA 1, indicated Resident B was found in a male resident's room with the door closed and the male resident was being inappropriate towards Resident B.

An incident report, dated 10/23/24 at 9:46 p.m., included a statement from CNA 2 indicating staff noticed Resident

The community's Director of Health and Wellness or their designee shall re-educate the community's current Qualified Medication Aides and Licensed Practical Nurses to the community's Incident Reporting expectations. This re-education shall be completed no later than 12/13/2024.

The community's Director of Health and Wellness, or their designee, shall educate newly hired Qualified Medication Aides and Licensed Practical Nurses during their initial orientation.

The community's Director of Health and Wellness, or their designee, shall audit the community's incident reports weekly for 4 weeks to ensure the resident's responsible party and/or legal representative and healthcare provider had been notified appropriately. The results of the Audit shall be reported to the community's Executive Director, and any incident not compliant with

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B was not in the common area. The staff began a room-to-room check. Resident B was located in a male resident's room, sitting in a recliner. The male resident had exposed himself and was standing in front of Resident B's face. The report indicated the Administrator and DON had been notified. The record lacked indication of family notification.

During an interview on 11/13/24 at 1:35 p.m., the DON indicated QMA 1 and the Memory Care Director had not notified Resident B's family of the incident. Resident B's family should have been notified of the incident.

During an interview on 11/13/24 at 2:52 p.m., QMA 1 indicated he was not aware he was supposed to notify the family.

A current facility policy, revised 9/25/24, titled, "Incident Reporting," provided by the DON on 11/13/24 at 3:19 p.m., indicated: "Standard Interpretation and Implementation...For the purposes of this Standard, an "incident" is defined as any situation, event, accident, or occurrence that is outside the normal course of operations...The Incident Report shall be completed in its entirety, including, but not limited to:....Notification of Manager on Duty, the resident's

notification to the resident's legal representative or the healthcare provider shall be notified immediately by the community's Director of Health and Wellness, or their designee, and documented within the resident's electronic medical record.

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FORM APPROVED

OMB NO. 0938-0391

POA/responsible person..."

This citation relates to
Complaint IN00445979.

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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.)

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