STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR FORK CROSSING	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 467966 and 468237. Intake 467966 - State deficiencies related to the allegations are cited at R052 and R217. Intake 468237 - State deficiencies related to the allegations are cited at R216, R241 and R414. Survey date: March 11 and 12, 2026 Facility number: 014080 Residential Census: 86 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed March 23, 2026.	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.	

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 observation, interview, and record review, the facility failed to protect a resident's right to be free from neglect when staff failed to respond to a resident's activated call light for 60 minutes after a resident had fallen on the bathroom floor and activated the call light to summon help for 1 of 3 residents reviewed for falls (Resident B). Findings include: Resident B's clinical record was reviewed on 3/11/26 at 2:50 p.m. Diagnoses included malignant neoplasm of colon, other fatigue, and syncope and collapse. A nurses note dated 3/8/2026 at 7:30 a.m. indicated the Certified Nurse Aide (CNA) answered the	R 0052	Resident B received a nursing assessment from the hospice nurse on 02/09/2026. No additional concerns noted during this assessment. Resident B received follow-up observation for 72 hours after this assessment by the community's Director of Health and Wellness. The community's Director of Health and Wellness, or their designee, shall complete an in-service utilizing the community's Abuse and Neglect Reporting guideline with current community Team Members no later than 04/30/2026. Team Members for which in-service has not been completed shall be removed from the community's work schedule until training has been completed satisfactorily. An Inservice Attendance Log shall be used as evidence of completion of such training and shall be maintained with the community's training files. New community Team Members shall be oriented to the community's Abuse and Neglect Reporting guideline at the time of hire. The community's Director of Health and Wellness, or their designee, shall complete an in-service utilizing the community's Preventing, Recognizing and Reporting	04/30/2026

	resident's call light. The resident was found lying on her right side on the bathroom floor, after she had rushed to get to the toilet, lost her balance and fell. A small knot was noted to the right side of her forehead. A review of the call light logs provided by the Maintenance Director on 3/12/26 at 10:30 a.m. indicated Resident B's call light was activated on 2/8/26 at 6:42 a.m. and answered at 7:42 a.m. During an interview on 3/12/26 at 9:50 a.m. Resident B pointed out a faded bruise and scab that had been removed from above her right eyebrow that she sustained from a fall. She indicated that her bowels were going to move and she got up during the night to use the bathroom, at approximately 4:30 a.m. Once in the bathroom, she became incontinent of bowel and felt that she might fall into the shower. When she turned, she fell to the floor and hit her head. She felt that she may had lost consciousness. She repeatedly pressed her call light. The staff did not respond until 7:00 a.m. and she had laid on the floor the entire time. During an interview on 3/12/26 at 11:34 a.m. the Maintenance Director reviewed the call light log, which showed 26 call light		Abuse guideline with current community Team Members no later than 04/30/2026. Team Members for which in-service has not been completed shall be removed from the community's work schedule until training has been completed satisfactorily. An Inservice Attendance Log shall be used as evidence of completion of such training and shall be maintained with the community's training files. New community Team Members shall be oriented to the community's Preventing, Recognizing, and Reporting Abuse guideline at the time of hire. The community's Executive Director will deploy "Abuse: Preventing, Recognizing and Reporting" training within Relias LMS to the community's current Team Members for completion no later than 4/30/2026. Team Members for which in-service has not been completed shall be removed from the community's work schedule until training has been completed satisfactorily. New community Team Members shall have the "Abuse: Preventing, Recognizing, and Reporting" module be deployed within Relias LMS for completion at the time of hire. The community's interim	

	response times that exceeded 30 minutes including 12 that were 60 minutes in duration. She indicated that when a resident activated a call light, the system began a countdown, and the activated call light appeared on the staff's tablet or phone. Once staff accepted the call light on the tablet or phone, they answered the call light, provided services to the resident, pressed the "finish" button on the tablet or phone, and documented what services they provided to the resident. She confirmed Resident B's call light response time was 60 minutes and noted other residents also had response times of 60 minutes. She was unsure whether the system capped off at 60 minutes and she would follow up with the call light company. She indicated that the call lights should be answered within 10 to 15 minutes. If not answered within 10 minutes, an email notification was sent to both her and the DON, and the Administrator were notified. During a follow up interview on 3/12/26 at 11:58 a.m. the Maintenance Director indicated the call light company confirmed that the system did not cap at one hour. The facility did not have a policy for call light response times.		Director of Health and Wellness, or their designee, shall complete an in-service for expectation of pendant response times with current community Team Members no later than 04/30/2026. Team Members for which the in-service has not been completed shall be removed from the community's work schedule until training has been completed satisfactorily. An Inservice Attendance Log shall be used as evidence of completion of such training and shall be maintained with the community's training files. New community Team Members shall be oriented to the community's expectation of pendant response times at the time of hire. Residents identified by this survey with delayed response times will have their pendants check to ensure proper working order by the Director of Facilities by 04/06/2026. During morning alignment the leadership team reviews our average pendant response time from the previous day as well as any call lights that have extended response times. The Director of Health and Wellness, and or their designee will monitor the pendant call report weekly to ensure the expected pendant call times are	

	During an interview on 3/12/26 at 3:05 p.m. the Administrator indicated the call lights should be answered within 15 minutes, but the facility had nothing in writing for this standard. If a call light had not been answered at either 15 or 30 minutes, she, the DON, and the Maintenance Director received text messages. She would text staff on duty if she was not in the building or use the walkie-talkie to instruct staff to answer the call light. This citation relates to Intake 467966.		within the average limit set during the community team member in-service. Pendant call times found to be outside of the call time average will be addressed with the care team member by re-inserviced and or corrective action. An in-service attendance log shall be used as evidence of completion of the re-inservice training and shall be maintained with the community's training files or a corrective action form will be maintained in the employees personnel file.	
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications.	R 0216	Resident K identified in the survey was assessed by the VA Nurse on 3.12.2026, no additional concerns noted. The community's interim Director of Health and Wellness will provide education with Resident K regarding the community's policy for medication management by 04/08/2026. An audit of all residents requiring supervision and or assistance during medication administration will be conducted by the community Director of Health and Wellness, or their designee by 04/15/2026 by reviewing the physicians' order, MAR/TAR and residents service	04/30/2026

	(d) The evaluation shall be documented in writing and kept in the facility. Based on observation, interview, and record review, the facility failed ensure a resident was supervised according to their service plan during a medication administration for 1 of 8 residents observed medication administration observations. (Resident K and QMA 3) Findings include: During a medication administration observation on Assisted Living 1 on 3/11/26 at 4:59 p.m. QMA 3 prepared Resident K's medications. Her medications included atorvastatin 20 milligram (mg) (cholesterol), Coreg 3.125 mg (blood pressure), pantoprazole sodium 40 mg (acid reflux), quetiapine 12.5 mg (antipsychotic), ranolazine 500 mg (for chest pain) and warfarin (blood thinner) 2.5 mg. QMA 3 knocked on Resident K's door, Resident K opened the door, and QMA 3 gave the resident a cup of water and her medications in a medication cup. QMA 3 asked the resident if she was going to take the medication and the resident indicated she would in a couple of hours. QMA 3 indicated okay and the resident's door closed.		plan. Any identified discrepancies will be corrected and reported by the Director of Health and Wellness, or their designee to the resident's healthcare provider and Executive Director. The community's Director of Health and Wellness, or their designee, shall complete an in-service for Medication Management policy with current Qualified Medication Aides and Licensed Practical Nurses no later than 04/30/2026. Qualified Medication Aides and Licensed Practical Nurses for which in-service has not been completed shall be removed from the community's work schedule until training has been completed satisfactorily. An Inservice Attendance Log shall be used as evidence of completion of such training and shall be maintained with the community's training files. New community Qualified Medication Aides and Licensed Practical Nurses shall be oriented to the community's Medication Management Policy at the time of hire. The community's Director of Health and Wellness, or their designee, shall complete an in-service on the Six (6) Rights of Medication Administration with current Qualified Medication Aides and Licensed	

	QMA 3 indicated that the resident was always like that, she used to do her own medications and didn't know why she was unable to take them herself as she did everything for herself. Resident K's clinical record was reviewed on 3/12/26 at 2:03 p.m. Diagnoses included muscle weakness, dysphagia following cerebral infarction and transient cerebral ischemic attack. Her current service, plan dated 1/7/26, indicated she required assistance for medication administration. A current facility policy, titled "Medication Management" and provided by the QMA Lead Care Partner on 3/12/26 at 2:53 p.m. indicated the following: "Guideline Interpretation and Implementation...4. The amount and type of assistance needed by a resident will be included in the resident's service plan...." This citation relates to Intake 468237.		Practical Nurses no later than 04/30/2026. Qualified Medication Aides and Licensed Practical Nurses for which in-service has not been completed shall be removed from the community's work schedule until training has been completed satisfactorily. An Inservice Attendance Log shall be used as evidence of completion of such training and shall be maintained with the community's training files. New community Qualified Medication Aides and Licensed Practical Nurses shall be oriented to the Six (6) Rights of Medication Administration at the time of hire. The community's Director of Health and Wellness, or their designee shall conduct random weekly medication pass observations of at least 3 residents requiring medication assistance to ensure that appropriate oversight and support is provided. Weekly observations will occur for 4 weeks, followed by monthly observations for 3 months. Findings with be reviewed with the community's Executive Director weekly and monthly, any non-compliance will result in re-education and/or disciplinary action with the Qualified Medication Aide and/or Licensed Practical Nurse and an in-service attendance log will be	

			placed in the community's training file, any disciplinary action will be placed in the employee's personnel file.	
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 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	R 0217	Resident D identified during the survey will have their service plan reviewed and updated by the community's Director of Health and Wellness by 04/08/2026. The updated service plan will be communicated to all applicable staff to ensure appropriate care interventions are implemented. Resident E identified during the survey will have their service plan reviewed and updated by the community's interim Director of Health and Wellness by 04/08/2026. The updated service plan will be communicated to all applicable staff to ensure appropriate care oversight and support implemented and updated in service plan.. The community's interim Director of Health and Wellness, or their designee will audit all residents changes of conditions and post fall to ensure the service plans accurately reflect each residents current condition and recent changes in status. Any service plans found to be outdated will be updated by the community's Director of Health and Wellness, or their designee	04/30/2026

	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. A. Based on record review and interview, the facility failed to ensure service plans were reviewed and updated after falls per facility policy for 2 of 4 residents reviewed for falls. (Residents D and E) B. Based on record review and interview, the facility failed to ensure service plans were reviewed and signed by residents and/or resident representatives after a change in condition for 2 of 4 residents reviewed for service plans. (Residents D and E) Findings include: A1. Resident D's clinical record was reviewed on 3/12/26 at 11:12 a.m. Diagnoses included recurrent major depressive disorder, unspecified dementia, and age-related osteoporosis. A 10/6/25, falls focused service plan indicated the resident will		to include appropriate interventions and care instructions by 04/30/2026. The community's interim Director of Health and Wellness has been educated on the community's service plan policy and the Indiana State Regulations by the community's Executive Director on 04/03/2026. An Inservice Attendance Log shall be used as evidence of completion of such training and shall be maintained with the community's training files. The community's interim Director of Health and Wellness, or their designee will conduct weekly audits of resident service plans for residents with documented changes in conditions and post fall events for 4 weeks, followed by monthly audits for 3 months. Results will be reviewed weekly with the community's Executive Director and any non-compliance service plans will be updated by the community's Health and Wellness Director, or their designee.	

	remain free from falls while living in the community. Interventions included the following: referral to therapy and a review of the service plan and update to reflect more care needed (3/4/26). The service plan lacked a resident and/or resident representative signature. A 10/7/25, Brief Interview for Mental Status (BIMS) assessment indicated the resident was moderately cognitively impaired. A 12/15/25, incident note indicated Resident D was found seated on her living room floor by the couch. The resident indicated she attempted to get up from the couch and slid off the edge. No injuries were noted. The incident note lacked a fall intervention. A 12/17/25, incident note indicated Resident D was found sitting on the floor outside the theater room. The resident indicated she was not sure what happened, she just fell forward out of her wheelchair. The incident note lacked a fall intervention. A 1/5/26, incident note indicated Resident D was found by physical therapy staff lying on her bedroom floor inside her apartment. No injuries were noted. The incident note lacked			

	a fall intervention. A 2/18/26, incident note indicated Resident D was found lying on her left side by the doctor's office in the hallway. The resident indicated her foot got stuck under her wheelchair, she was going to fast, and fell out of the wheelchair. The resident complained of right knee pain. The resident refused a hospital transfer for an evaluation. The incident note lacked a fall intervention. A 2/19/26, incident note indicated Resident D was found sitting on the floor in front of her couch. She indicated she had just slid off the couch when trying to get up. The incident note lacked a fall intervention. A 2/24/26, Interdepartmental (IDT) review note indicated the resident was encouraged to slow down and be aware of her surroundings. A 3/4/26, incident note indicated Resident D was found lying on the floor between her bed and a dresser in her bedroom. The resident indicated she was trying to get to her wheelchair and fell. The incident note lacked a fall intervention. A 3/4/26, IDT review note indicated the resident's service plan was being reviewed and updated to reflect the need for			

	more care. A 3/6/26, incident note indicated Resident D was found lying on the floor near her couch with a pillow under her head. She indicated she was not in pain. The incident note lacked a fall intervention. A2. Resident E's clinical record was reviewed on 3/11/26 at 12:18 p.m. Diagnoses included unspecified dementia, chronic obstructive pulmonary disease (COPD), and osteoarthritis. A 2/24/26, falls service plan indicated the resident will remain free from falls while living in the community. Interventions included the following: clutter free; support/assistive devices are available and in good repair (2/24/26), medication review (2/24/26), encourage use of wheelchair (3/4/26). The service plan lacked a resident and/or resident representative signature. A 2/24/26, BIMS assessment indicated the resident was unable to answer the questions and required further assessment. A 2/2/26, incident note indicated Resident E was found lying on the floor next to a cupboard in the lounge area. No injuries were noted. The incident note			

	lacked a fall intervention. A 2/2/26, communication note indicated Resident E was sent to the emergency room for evaluation after a fall. The resident had complained of back pain. A 2/4/26, incident note indicated Resident E was found on the floor in front of her bathroom door. The resident was sent to the hospital. The incident note lacked a fall intervention. A 2/11/26, incident note indicated Resident E was found sitting on the floor next to her bed. The resident indicated no pain and did not want to be sent to the hospital. The incident note lacked a fall intervention. A 2/11/26, incident note indicated Resident E was found sitting upright on the floor in front of her roommate's bed. The fall was unwitnessed and an ambulance was called. The incident note lacked a fall intervention.			

	A 2/18/26, incident note indicated Resident E was found lying on the floor in front of her recliner. The resident indicated she had fallen and hit her head. The resident complained of back pain. The resident was sent to the hospital. The incident note lacked a fall intervention. A 2/19/26, incident note indicated Resident E was found sitting on the floor by her bed. The resident complained of knee pain and was sent to the hospital. The incident note lacked a fall intervention. A 2/23/26, incident note indicated Resident E was found on the floor in front of her bed. No injuries were noted. The incident note lacked a fall intervention. A 2/25/26, incident note indicated Resident E was sitting on the floor in front of her recliner. No injuries were noted. The incident note lacked a fall intervention. A 2/25/26, incident note indicated Resident E was found on the floor in front of her roommate's bed. No injuries were noted. The incident note lacked a fall intervention. A 2/26/26, incident note indicated Resident E was found sitting on the floor between her			

	bed and recliner. The resident indicated she was trying to use the bathroom. The incident note lacked a fall intervention. A 2/27/26, incident note indicated Resident E was found sitting on the floor beside her bed. The resident indicated she rolled over and slid out of bed. She indicated she hit her head on the bedside table. A small knot was found on the back of her head. The resident's representative was contacted and requested she be sent to the hospital for evaluation. The incident note lacked a fall intervention. A 2/27/26, incident note indicated Resident E was found sitting on the floor in front of her bed. The resident indicated she had fallen out of bed. The incident note lacked a fall intervention. A 3/4/26, IDT review note indicated to encourage the resident to start using her wheelchair. During an interview, on 3/12/26 at 2:36 p.m., QMA 3 indicated when she found a resident who had fallen, she immediately checked on them. She contacted the nurse and grabbed a full set of vitals. She remained available to assist the nurse after any resident's fall. She would document in the			

	clinical record what she witnessed. During an interview, on 3/12/26 at 2:36 p.m., the Memory Care Director indicated when a resident fell, she assessed the resident, obtained a full set of vitals, and gathered as much information as possible about the fall. She would contact the resident's family, the physician, the DON, and the Administrator. If the resident needed to be sent to the hospital, she would call for transportation. The situation and all the information would be documented in the resident clinical record. The IDT would determine the root cause of any fall and develop an intervention to prevent further falls. This information would be documented in the residents' service plan. If a resident had fallen multiple times, they would need a fall intervention listed for each fall. The staff would follow-up for three (3) days with residents who had fallen. Residents D and E had both fallen multiple times and should have appropriate fall interventions in place to assist with prevention of future falls. A facility policy, revised 7/8/25, titled, "Falls Management", provided by QMA 4 on 3/12/26 at 2:55 p.m., indicated the following: " ...Team members shall utilize resident evaluations			

	to identify individualized interventions based on each resident's unique profile. These proactive strategies are intended not only to help prevent falls, but also to reduce the likelihood of injury and support overall well-being ...The comprehensive evaluation shall be used to establish an individualized Service Plan with personalized approaches to prevent recurrence of falls ...The community's Director of Health and Wellness, or their licensed nurse designee, shall oversee implementation of the Fall Management program which may include: ... Development of an individualized Service Plan outlining intervention(s) necessary to address fall risk factors identified during the comprehensive resident evaluation ...Update the resident's service plan to include any new interventions identified to try and prevent further falls, as needed. Resident should be added to the community's IDT meeting review for at least the following week to ensure approaches and interventions for further fall prevention are effective.			

	B1. Resident D's clinical record was reviewed on 3/12/26 at 11:12 a.m. Diagnoses included recurrent major depressive disorder, unspecified dementia, and age-related osteoporosis. A 10/6/25, "Care Evaluation and Service Plan" assessment was completed related to a change in condition. The change of condition was related to Resident D requiring more care related to multiple falls. A 10/6/25, falls service plan indicated the resident will remain free from falls while living in the community. Interventions included the following: referral to therapy and a review of the service plan and update to reflect more care needed (3/4/26). The service plan lacked a resident and/or resident representative signature. A 10/7/25, Brief Interview for Mental Status (BIMS) assessment indicated the resident was moderately cognitively impaired. B2. Resident E's clinical record was reviewed on 3/11/26 at 12:18 p.m. Diagnoses included unspecified dementia, chronic obstructive pulmonary disease (COPD), and osteoarthritis. A 2/24/26, "Care Evaluation and Service Plan" assessment was			

	completed related to a change in condition. The change of condition was due to Resident E requiring more care related to multiple falls. A 2/24/26, falls service plan indicated the resident will remain free from falls while living in the community. Interventions included the following: clutter free; support/assistive devices are available and in good repair (2/24/26), medication review (2/24/26), encourage use of wheelchair (3/4/26). The service plan lacked a resident and/or resident representative signature. A 2/24/26, BIMS assessment indicated the resident was unable to answer the questions and required further assessment. A 3/12/26, review of the signed service plans, provided by QMA 4 on 3/12/26 at 2:55 p.m., indicated the following: Resident D's signed service plan was dated 3/10/25 and signed by the resident representative on 3/29/25. The most recent/current updated service plan was dated 10/6/25 and lacked a resident and/or resident representative signature. Resident E's signed service plan was dated 8/19/25 and signed by the resident			

	representative on 9/23/25. The most recent/current updated service plan was dated 2/24/26 and lacked a resident and/or resident representative signature. During an interview, on 3/12/26 at 3:29 p.m., the Administrator indicated the facility did not have a policy for her to provide. She indicated that service plans were updated on admission, for a change in condition, and semi-annually. The facility followed the regulations regarding when service plans were to be completed. During an interview, on 3/12/26 at 3:30 p.m., the Memory Care Director indicated service plans were updated when a resident had a change of condition such as when they require more care, have multiple falls, or a change in health status, the facility will do a re-assessment. The resident and the resident's family can be present. The staff reviewed the questions and areas of care with the residents and families to highlight any changes. Doing this processes the new care levels and this information was used to determine cost. This information would be reviewed with the residents and resident representatives. Then they would print out the new evaluation and service plan and			

	ask the resident and/or resident representative to sign the documents. The signed service plans provided by QMA 4 for Resident's D and E were not the most current or up to date service plans. Resident D's 10/6/25 service plan should have been reviewed and signed by the resident and/or resident representative. Resident E's 2/24/26 service plan should have been reviewed and signed by the resident and/or resident representative. A facility policy was not provided prior to exit. This citation relates to Intake 467966.			
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. A. Based on observation, interview, and record review, the facility failed to ensure the	R 0241	The community's interim Health and Wellness Director and or their designee shall review the residents identified in this survey by 04/08/2026 to ensure any medication administration preferences for administration times are adjusted and the residents Primary Care Physician will be notified and the residents medical records will be updated with the updated medical information. The QMA identified during this survey self-terminated and no additional education could be provided.	04/30/2026

	correct dose of medication was administered to a resident (Resident H) and medication was administered to a resident (Resident G) at the correct time by a Qualified Medication Aide (QMA) for 1 of 3 medication administration observations. (QMA 16 on the Memory Care Unit) The facility also failed to ensure residents received their medication according to their physicians' orders for 4 of 8 resident clinical records reviewed. (Resident E, C, F and G) Findings include: During a medication administration observation in the memory care unit with QMA 16 on 3/11/26 the following was observed: At 6:33 p.m., QMA 16 exited a resident's room near the nurse's station and without performing hand hygiene she prepared Resident H's medication. She removed the bottle of acetaminophen (pain reliever) 500 milligram (mg) from the cart, dispensed two pills into the palm of her bare hand, and placed the pills in the medication cup. She removed the bottle of mirtazapine (antidepressant) 7.5 mg from the cart and reviewed the instructions on bottle. Written in permanent marker on top of the		An audit of all memory care neighborhood residents medication administration will be conducted by the interim Director of Health and Wellness, or their designee by 04/15/2026 by reviewing the physicians' order, MAR/TAR and residents service plan. Any identified discrepancies will be corrected and reported by the interim Director of Health and Wellness, or their designee to the resident's healthcare provider. The community's Director of Health and Wellness, or their designee, shall complete an in-service for Medication Management policy with current Qualified Medication Aides and Licensed Practical Nurses no later than 04/30/2026. Qualified Medication Aides and Licensed Practical Nurses for which in-service has not been completed shall be removed from the community's work schedule until training has been completed satisfactorily. An Inservice Attendance Log shall be used as evidence of completion of such training and shall be maintained with the community's training files. New community Qualified Medication Aides and Licensed Practical Nurses shall be oriented to the community's Medication Management Policy at the time of hire.	

	bottle indicated two pills were to be given at 8:00 p.m. She indicated that she didn't know why that was written on the top of the bottle because the resident only received one pill, not two. She administered the resident's medication and returned to the medication cart. She reviewed the Medication Administration Record (MAR) on the computer screen and read out loud the order for mirtazapine was 15 mg and indicated that the resident was to receive one pill. At 6:45 p.m., without performing hand hygiene, QMA 16 prepared and administered Resident G's medication. The MAR indicated at 5:00 p.m. Resident G was to receive buspirone (treat anxiety) 30 mg, at 7:00 p.m. she was to receive atorvastatin (treat cholesterol) 20 mg, baclofen (muscle relaxant) 10 mg, risperidone (antipsychotic) 1 mg and donepezil (treat dementia) 5 mg and at 8:00 p.m. she was to receive two senna (treat constipation) 8.6 mg, fiber lax (treat constipation) 625 mg, melatonin (treat insomnia) 3 mg, two gabapentin (treat neuropathy) 100 mg and two acetaminophen 325 mg. QMA 16 indicated that Resident G would not take her medication if offered at separate times, and she waited until closer to 7:00		The community's interim Director of Health and Wellness, or their designee, shall complete an in-service on the Six (6) Rights of Medication Administration with current Qualified Medication Aides and Licensed Practical Nurses no later than 04/30/2026. Qualified Medication Aides and Licensed Practical Nurses for which in-service has not been completed shall be removed from the community's work schedule until training has been completed satisfactorily. An Inservice Attendance Log shall be used as evidence of completion of such training and shall be maintained with the community's training files. New community Qualified Medication Aides and Licensed Practical Nurses shall be oriented to the Six (6) Rights of Medication Administration at the time of hire. The community's interim Director of Health and Wellness, or their designee, shall assign Hand Hygiene Relias Training to the community's Qualified Medication Aides and Licensed Practical Nurses to complete no later than 04/30/2026. Qualified Medication Aides and Licensed Practical Nurses for which in-service has not been completed shall be removed from the community's work schedule until training has been	

	p.m. to give Resident G her evening medications and her buspirone was supposed to be given at 5:00 p.m. At 6:54 p.m., without performing hand hygiene, QMA 16 prepared memantine (treat dementia) 5 mg and olanzapine (antipsychotic) 2.5 mg for Resident G. The resident was lying on the couch in the common area. QMA 16 assisted her to a sitting position and handed her the medication cup. The resident dropped the medication cup, and the pills fell to the carpeted floor. QMA 16 picked up one of the pills off the floor near where the resident sat and placed the pill in the medication cup. Certified Nurse Aide (CNA) 7, standing nearby, pointed out the other pill that was lying at the end of the couch near a wheelchair. QMA 16 picked up the pill from the floor and placed it in the medication cup and administered the medication to the resident. QMA 16 indicated she would normally pick up the pills and administer them to the residents if they fell onto the carpet but not on the hard wood floor. If she did not give the resident her medication, she would have to open the resident's medication package for the next day and call the pharmacy. They did not have an Emergency Drug Kit (EDK) in		completed satisfactorily. An Inservice Attendance Log shall be used as evidence of completion of such training and shall be maintained with the community's training files. New community Qualified Medication Aides and Licensed Practical Nurses shall be assigned Hand Hygiene at the time of hire. The community's Health and Wellness, or their designee will conduct random weekly medication pass observations for at least 3 residents in memory care and include observation for infection control practice and hand hygiene during medication administration for the next 4 weeks, followed by monthly observations for 3 months. Findings with be reviewed with the community's Executive Director weekly and monthly, any non-compliance will result in re-education and/or disciplinary action with the Qualified Medication Aide and/or Licensed Practical Nurse and an in-service attendance log will be placed in the community's training file, any disciplinary action will be placed in the employee's personnel file.	

	the building. At 7:04 p.m., the MAR showed medications that indicated were late. QMA 16 indicated she was withholding Resident F's medication because the resident's husband had asked her not to give them because the resident was sleeping. Resident F's clinical record was reviewed on 3/12/26 at 12:32 p.m. Diagnoses included Alzheimer's disease, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, anxiety, abnormal weight loss, repeated falls, essential hypertension and tremors. Her MAR indicated QMA 16 documented on 3/11/26 that the resident was sleeping. Medications included acetaminophen 650 mg at 4:00 p.m., melatonin 5 mg, midodrine (treat low blood pressure) 2.5 mg, quetiapine (antipsychotic) 25 mg, trazodone (antidepressant) 100 mg, clonazepam (treat anxiety) 0.5 mg, senna-S 8.6/50 mg, morphine (treat pain) 20mg/ml (milliliters), and tizanidine (muscle relaxant) 4 mg. The clinical record lacked documentation of a nurse or physician notification related to			

	QMA 16 withholding the resident's medication. Resident E's clinical record was reviewed on 3/11/26 at 12:18 p.m. Diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, essential hypertension, anxiety disorder, osteoarthritis and chronic gout. Medications included clonazepam 0.5 mg at 8:00 a.m. and 2:00 p.m., risperidone 2 mg at 7:00 a.m. and 7:00 p.m., and escitalopram (antidepressant)10 mg at 7:00 a.m. Her MAR lacked documentation that medications were administered on 2/14/26. Resident C's clinical record was reviewed on 3/11/26 at 3:22 p.m. Diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, unspecified combined systolic (congestive) and diastolic (congestive) heart failure, unspecified chronic pain and general anxiety disorder. Medications included furosemide (treat blood pressure) 40 mg at 8:00 a.m.,			

	lorazepam (treat anxiety) 0.25 ml at 7:01 a.m. and 12:01 p.m., lorazepam 0.5 ml at 7:01 p.m., and morphine concentrate 0.5 ml at 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m. His MAR lacked documentation that medications were administered on 2/14/26. Resident F's clinical record was reviewed on 3/12/26 at 12:32 p.m. Diagnoses included Alzheimer's disease, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, anxiety, abnormal weight loss, repeated falls, essential hypertension and tremors. Medications included haloperidol (antipsychotic)15 ml in the morning, midodrine 2.5 mg at 8:00 a.m. and 7:00 p.m., quetiapine 25 mg at 8:00 a.m. and 7:00 p.m., trazodone 100 mg at 8:00 p.m., clonazepam 0.5 mg at 8:00 a.m. and 5:00 p.m., morphine concentrate 0.25 ml at 8:00 a.m., 12:00 p.m. and 7:00 p.m., and tizanidine 4 mg at 8:00 a.m., 12:00 p.m. and 8:00 p.m. Her MAR lacked documentation that medications were administered on 2/14/26. Resident G's clinical record was			

	reviewed on 3/12/26 at 1:53 p.m. Diagnoses included essential hypertension, chronic kidney disease, stage 4 (severe), type II diabetes mellitus without complications, acute respiratory infection, major depressive disorder, abnormal weight loss, chronic pain syndrome, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, primary insomnia, thyrotoxicosis, unspecified without thyrotoxic crisis or storm, and pain in left shoulder. Medications included levothyroxine (treat thyroid) 50 microgram (mcg) at 8:00 a.m., amlodipine (treat blood pressure) 10 mg at 7:00 a.m., atorvastatin 20 mg at 7:00 p.m., baclofen 10 mg at 7:00 p.m., bupropion (antidepressant) 150 mg at 7:00 a.m., risperidone 0.5 mg in the morning, tradjenta (treat diabetes) 5 mg at 7:00 a.m., venlafaxine (treat anxiety) 150 mg at 7:00 a.m., buspirone at 12:00 p.m. and 5:00 p.m., budesonide/formoterol aerosol (treat respiratory issues) 160-4.5 two puffs at 7:00 a.m. and 7:00 p.m., risperidone 1 mg at 7:00 p.m., and donepezil (treat dementia)10 mg at 8:00 p.m.. Her MAR lacked documentation			

	that medications were administered on 2/14/26. During an interview on 3/12/26 at 1:31 p.m. the Administrator indicated the Director of Nursing (DON) worked third shift on 2/14/26 and then returned to work on 2/15/26. She remembered it because they had a Valentine's brunch that day. The DON should have caught it on her missed medication report. During a follow up interview on 3/12/26 at 3:05 p.m., the Administrator indicated that QMA 16 had worked on 2/14/26 and provided QMA 16's timesheet. The timesheet indicated QMA 16 clocked in at 6:59 a.m. and clocked out at 5:40 p.m. A current facility policy, titled "Medication Management," and provided by the QMA Lead Care Partner on 3/12/26 at 2:53 p.m., indicated the following: "Guideline Interpretation and Implementation...3. Staff assisting with or administering medications with follow the 7 rights of medication administration to include: right resident, right dose, right drug, right route, right time, right time, right reason, right documentation...."			

	This citation relates to Intake 468237.			
R 0414	Infection Control - Deficiency 410 IAC 16.2-5-12(k) (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, interview, and record review, the facility failed to ensure a Qualified Medication Aide (QMA) performed hand hygiene between residents during medication administration and administered medication in a sanitary manner. (QMA 16) Findings include: 1. During a medication administration observation in the memory care unit with QMA 16 on 3/11/26 the following was observed: At 6:33 p.m., QMA 16 exited a resident's room near the nurse's station and without performing hand hygiene she prepared Resident H's medication. She removed the bottle of acetaminophen (pain reliever) 500 milligram (mg) from the cart, dispensed two pills into the palm of her bare hand, and placed the pills in the	R 0414	The staff member identified during this survey observation self-terminated, no further education could be conducted. No residents were harmed as a result of the deficient practice. The community's Director of Health and Wellness, or their designee, shall complete an in-service for Medication Management policy with current Qualified Medication Aides and Licensed Practical Nurses no later than 04/30/2026. Qualified Medication Aides and Licensed Practical Nurses for which in-service has not been completed shall be removed from the community's work schedule until training has been completed satisfactorily. An Inservice Attendance Log shall be used as evidence of completion of such training and shall be maintained with the community's training files. New community Qualified Medication Aides and Licensed Practical Nurses shall be oriented to the community's Medication Management Policy at the time of hire. The community's Director of Health and Wellness, or their designee, shall complete an in-service for the community's	04/30/2026

	medication cup. At 6:41 p.m., without performing hand hygiene, QMA 16 prepared and administered Resident E's medication. At 6:45 p.m., without performing hand hygiene, QMA 16 prepared and administered Resident G's medication. At 6:54 p.m., without performing hand hygiene, QMA 16 prepared memantine (treat dementia) 5 mg and olanzapine (antipsychotic) 2.5 mg for Resident G. The resident was lying on the couch in the common area. QMA 16 assisted her to a sitting position and handed her the medication cup. The resident dropped the medication cup, and the pills fell to the carpeted floor. QMA 16 picked up one of the pills off the floor near where the resident sat and placed the pill in the medication cup. CNA 7, standing nearby, pointed out the other pill that was lying at the end of the couch near a wheelchair. QMA 16 picked up the pill from the floor and placed it in the medication cup and administered the medication to the resident. QMA 16 indicated she would normally pick up the pills and administer them to the residents if they fell onto the carpet but not on the hard wood floor. If she did not give the resident her medication, she		infection control policy with current Qualified Medication Aides and Licensed Practical Nurses no later than 04/30/2026. Qualified Medication Aides and Licensed Practical Nurses for which in-service has not been completed shall be removed from the community's work schedule until training has been completed satisfactorily. An Inservice Attendance Log shall be used as evidence of completion of such training and shall be maintained with the community's training files. New community Qualified Medication Aides and Licensed Practical Nurses shall be oriented to the community's Infection Control Policy at the time of hire. The community's Director of Health and Wellness, or their designee, shall assign Hand Hygiene Relias Training to the community's Qualified Medication Aides and Licensed Practical Nurses to complete no later than 04/30/2026. Qualified Medication Aides and Licensed Practical Nurses for which in-service has not been completed shall be removed from the community's work schedule until training has been completed satisfactorily. An Inservice Attendance Log shall be used as evidence of completion of such training and shall be maintained with the	

	would have to open her medication package for the next day and call the pharmacy. They did not have an Emergency Drug Kit (EDK) in the building. During an interview on 3/11/26 at 7:23 p.m. QMA 16 indicated she should carry her hand sanitizer spray in her pocket, but it was in her bag. She would normally use the hand sanitizer on the walls between residents. A current facility policy, titled "Medication Management," and provided by the QMA Lead Care Partner on 3/12/26 at 2:53 p.m. indicated the following: "Guideline Interpretation and Implementation...2. Staffing assisting with or administering medications must follow the community's infection control procedures when providing assistance..." This citation relates to Intake 468237.		community's training files. New community Qualified Medication Aides and Licensed Practical Nurses shall be assigned Hand Hygiene at the time of hire. The community's Director of Health and Wellness, or their designee will perform hand hygiene observations of all Qualified Medication Aides and Licensed Practical Nurses by 4/17/2026. In addition they shall conduct random hand hygiene observations during medication administration for the next 4 weeks followed by monthly observations for 3 months. Findings will be reviewed with the community's Executive Director weekly and monthly, any non-compliance will result in re-education and/or disciplinary action with the Qualified Medication Aide and/or Licensed Practical Nurse and an in-service attendance log will be placed in the community's training file, any disciplinary action will be placed in the employee's personnel file.	

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 SIGNATURELorena Glover	TITLEExecutive Director	(X6) DATE04/05/2026