STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/04/2026

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 Intake 469090. Intake 469090 - State deficiency related to the allegation is cited at R0247. Survey date: May 1 and 4, 2026 Facility number: 014080 Residential Census: 83 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed May 12, 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 0247	Health Services - Deficiency 410 IAC 16.2-5-4(e)(7) (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when	R 0247	Resident B identified in the survey was assessed by Bryon Miller, NP on 04/08/2026. No adverse effects were reported. Resident B service plan was reviewed on 04/07/2026 and updated to reflect current medication needs and	06/21/2026

	there are any actual or potential detrimental effects to the resident. Based on record review and interview, the facility failed to ensure physician orders were followed appropriately resulting in an opioid medication error for 1 of 3 residents reviewed for medication administration. (Resident B) Findings include: Resident B's clinical record was reviewed on 5/1/26 at 10:15 a.m. Diagnoses included unspecified dementia, chronic pain syndrome, and chronic atrial fibrillation. Current orders included the following: give one Tramadol (opiate pain medication) 300 mg tablet by mouth once a day between 8:00 a.m. and 10:00 a.m. for pain (10/31/25) and give one Tramadol 50 mg tablet by mouth once a day at 8:00 a.m. and one tablet every 24 hours as needed for pain (4/7/26). Discontinued orders included give one Tramadol 50 mg tablet by mouth once a day at 5:00 p.m. for pain. (2/16/25). A 1/8/26, service plan indicated Resident B made safe judgments and required assistance with medication administration. A 4/7/26, incident note indicated		pharmacy notification. An audit of the community's current Memory Care residents' medication administration shall be conducted by the community's interim Director of Health and Wellness, or designee no later than 6/5/2026. In this audit, a review shall occur of the physicians' order, MAR/TAR and available medications to identify consistency. In the event that discrepancies are identified, such discrepancies shall be corrected and reported to the residents healthcare provider by the community's interim Director of Health and Wellness, or their designee. The community’s Interim Director of Health and Wellness, or their designee, shall complete an in-service to the community’s Medication Management policy with the community’s current Qualified Medication Aides and Licensed Practical Nurses no later than 6/20/2026. Qualified Medication Aides and Licensed Practical Nurses who do not complete this in-service by 6/20/2026 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	

	the facility was alerted to a medication error by a QMA. During an investigation the DON discovered the resident had received one Tramadol 300 mg tablet in place of the ordered Tramadol 50 mg tablet. The repeated error occurred on the following dates: 3/28/26, 3/29/26, 3/31/26, 4/1/26, 4/3/26, 4/4/26, 4/5/26, and 4/6/26. The Tramadol 50 mg medication was not in the medication cart. The nurse practitioner (NP) and Administrator were notified. The NP was asked to fax an order to the pharmacy so the correct doses would be in the cart to prevent the error from occurring again. Resident B had not displayed adverse effects to the medication error. During an interview, on 5/1/26 at 11:33 a.m. QMA 3 indicated Resident B had received her Tramadol 300 mg morning dose, but she had withheld the Tramadol 50 mg dose as it was timed wrong on the electronic medical record (EMAR). She knew the medication was timed wrong because the order "up in the front" stated the Tramadol 50 mg was to be given at 5:00 p.m. every evening. The pharmacy was responsible for adding all medication orders to the facility EMAR and the facility was waiting for the order to be corrected. QMA 3 indicated if a new staff member or an agency		community's training files. New community Qualified Medication Aides and Licensed Practical Nurses shall be oriented to the community's Medication Management Policy during their New Hire Onboarding. The community's Interim Director of Health and Wellness, or their designee, shall complete an in-service on the Basics of Medication Administration and Documentation of Medications with the community's current Qualified Medication Aides and Licensed Practical Nurses with a post test to verify knowledge after training no later than 6/20/2026. Qualified Medication Aides and Licensed Practical Nurses who do not complete this in-service by 6/20/2026 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 Basics of Medication Administration and Documentation of Medications during their New Hire Onboarding. The community's Interim	

	staff member was unaware of the order being timed wrong, that Resident B might get both the Tramadol 300 mg and the Tramadol 50 mg at the same time in the morning. QMA 3 indicated that when a medication was withheld or missing from the medication cart, the staff would document this in the resident's clinical record. Employee Records provided by the Administrator on 5/1/26 at 12:16 p.m. were reviewed on 5/1/26 at 12: 16 p.m. and indicated that QMA 7, QMA 8, and QMA 9 had worked at the facility through a staffing agency. Review of the "Controlled Drug Receipt/Record/Disposition" forms, provided by QMA 4 on 5/1/26 at 1:40 p.m., were reviewed on 5/1/26 at 1:40 p.m., and indicated the following: A Tramadol 50 mg narcotic record showed there were zero pills remaining on 3/16/26. A Tramadol 50 mg narcotic record started on 4/8/26 when the medication was delivered to the facility. A Tramadol 300 mg narcotic record showed the medication was signed out as given on the following dates and times: on 3/17/26 at 8:00 a.m. and 5:00		Director of Health and Wellness, or their designee, shall conduct random weekly medication pass observations sampling all shifts for at least 3 residents in the community’s memory care environment for the next 4 weeks, followed by monthly observations for 3 months. Findings shall be reported to the community’s Executive Director, and any non-compliance shall result in corrective action with the Qualified Medication Aide and/or Licensed Practical Nurse.If non-compliance continues during the specified observation time, continued observation shall occur weekly for an additional month, and monthly for an additional three months. The community will be incompliance upon completion of the training on 6/21/26.	

p.m., 3/18/26 at 8:00 a.m. and 5:53 p.m., 3/21/26 at 8:00 a.m. and 5:49 p.m., 3/22/26 at 8:00 a.m. and 8:00 p.m., 3/23/26 at 8:00 a.m. and 6:00 p.m., 3/28/26 at 8:08 a.m. and 4:30 p.m., 3/29/26 at 8:00 a.m. and 7:15 p.m., 3/31/26 at 8:00 a.m. and 4:08 p.m., 4/1/26 at 8:00 a.m. and 7:23 p.m., 4/3/26 at 8:00 a.m. and 7:42 p.m., 4/4/26 at 8:00 a.m. and 5:00 p.m., 4/5/26 at 8:00 a.m. and 7:00 p.m., and 4/6/26 at 9:00 a.m. and 4:58 p.m.

During an interview, on 5/1/26 at 1:40 p.m. QMA 4 indicated the facility was made aware of a medication error for Resident B's Tramadol medication by another staff member. The narcotic record showed when the incorrect doses of Tramadol were given. When a nurse or QMA gave medication to a resident, they should be checking to ensure the medication is the correct one, in the correct dose, and at the correct time.

Review of the facility incident investigation file, provided by the Administrator on 5/1/26 at 3:30 p.m., was reviewed on 5/4/26 at 9:20 a.m., and indicated the following: The "Incident Investigation" document indicated the date of the incident was 4/2/26. The root cause of the error was the

medication cart did not have the correct Tramadol 50 mg dose. The NP and the resident's family were notified. The NP re-evaluated this resident on 4/9/26 without concerns.

A 4/2/26, facility self -reported incident indicated the following: "Brief Description of Incident", Resident B received an incorrect medication dose of Tramadol Extended Release (ER) tablet 300 milligram instead of the prescribed Tramadol 50 mg evening dose. Qualified Medication Aide (QMA) 7, QMA 8, and QMA 9 were agency staff identified as having made the medication errors. There were no injuries noted. The immediate action taken was to notify the Director of Nursing (DON), the physician, and the resident's family. The medication order was corrected.

During an interview, on 5/4/16 at 8:17 a.m., QMA 5 indicated she checked to ensure each resident gets the right medication in the right dose at the right time by the right route. She reviewed all medications were correct before giving them to a resident. If a medication was missing, she would see if it was reordered already and report to the DON.

On 5/4/26 at 8:32 a.m. QMA 6 indicated she used the five rights of medication

	administration with every resident. She double checked to make sure the right resident was getting the correct medications in the correct doses and that the order was current with the correct route. QMA 6 indicated if the medication was missing, she would contact the pharmacy to ensure it was ordered. She thought the pharmacy had made mistakes previously and she felt they needed to be watched. On 5/4/26 at 9:31 a.m., the DON indicated she was made aware of the medication error from a staff member working on 4/7/26. Resident B had gotten the wrong dose of Tramadol over multiple days. The only medication review she completed was for Resident B. The resident's physician and family were notified on the day the medication error was brought to her attention. The facility utilized agency staff to fill in holes on the schedule. The agency staff were held to the same standard nursing practices as the facility staff. QMA 7, QMA 8, and QMA 9 would have been expected to follow the five rights of medication administration. The QMAs should have verified the right resident, the right medication, the right dose, the right time, and the right route, prior to giving all medications.			

The QMAs signed the narcotic sheets when they removed the 300 mg Tramadol dose and gave it to the resident in place of the correct 50 mg Tramadol dose. This error was preventable if the QMAs had followed the appropriate medication administration rights.

QMA 7, QMA 8, and QMA 9 were not available for interview during the survey period.

A current facility policy, revised 8/11/23, titled, "Medication Management", provided by the Administrator on 5/4/26 at 9:38 a.m., indicated the following: "... 3. Staff assisting with or administering medications will follow the 7 rights of medication administration to include: right resident, right dose, right drug, right route, right time, right reason, right documentation... 6. The resident's Physician or Health Care Practitioner must be contacted when: a. Community staff observe medications not being taken as prescribed, b. Staff have any questions regarding the medication instructions or physician orders that need clarification... d. Medications are unavailable for administration. Documentation of contact with Resident's Health Care Practitioner or physician for any of the above reasons will be documented in the resident's

	record...11. In cases of not following the physician order, the physician and responsible party will be notified. The event will be documented in the resident's record... 17. Medication errors will be reported to the Health and Wellness Director/Designee. The Health and Wellness Director/Designee will notify the Resident's Health Care Provider and follow the Health Care Providers instructions. The Health and Wellness Director/Designee will notify the Resident's responsible party. The Health and Wellness Director/Designee will complete an incident report and if necessary, a state reportable within the required time frame..." This citation relates to Intake 469090.			

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	TITLEESL Executive Director	(X6) DATE05/23/2026