STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUGAR FORK CROSSING	1745 EAST 67TH STREET ANDERSON, IN 46013

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00405033 and IN00402597. Complaint IN00405033 - No State Residential Findings related to the allegations were cited. Complaint IN00402597 - State deficiencies related to the allegations are cited at R0052, R0053 and R0090. Survey dates: April 10 and 11, 2023 Facility number: 014080 Residential Census: 95 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed April 13, 2023.	R 0000		
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (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 interview and record review, the facility failed to prevent resident to resident abuse when a cognitively impaired male resident was found in bed with a cognitively impaired female resident (Resident C and Resident G) . The facility also failed to prevent resident to resident abuse when a cognitively impaired female resident (Resident	R 0052	1. Resident C was seen by facility Nurse Practitioner and started on new medications. Resident G was interviewed by facility staff and wanted her apartment door locked. Family notified and they agreed with this	05/01/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Susan Waymire	Executive Director	05/02/2023

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	B) entered the room of a cognitively impaired male resident (Resident G) and removed her clothing. Using the common person concept, these actions could cause anxiety or embarassment for the residents involved. Findings include: 1. During an interview on 4/10/2023 at 12:24 p.m., the Director of Nursing (DON) indicated she had been told of an incident where Resident B was found, partially unclothed, in Resident C's room. During a confidential interview, Employee 1 indicated Resident B was found disrobing in Resident C's room. Employee 1 attempted to redirect Resident B, when they became aggressive and walked through the unit, partially dressed, and returned to their own room. During a confidential interview, Employee 8 indicated they saw Resident B in Resident C's room. Resident B was naked from the waist down and the clothing was on the bed or the chair. Employee 8 indicated they reported the incident to the nurse on duty. During a confidential interview, Employee 9 indicated staff reported Resident B was partially dressed in Resident C's room. Employee 9 was not sure who the incident was reported to. The clinical record for Resident B was reviews on 4/10/2023 at 11:20 a.m. Diagnoses included hypothyroidism, Alzheimer's Disease, dementia and depressive disorder. The resident resided on the secured memory care unit. No interventions were put into place to prevent recurrence. The clinical record for Resident C was reviewed		plan. Resident G is no longer at the facility, however facility received permission from family for contact with male resident. 2. Memory Care Director called all residents families to ask about any concerns related to resident abuse. No other concerns identified. Executive Director and Nursing Director completed interviews with interviewable residents on Memory Care and no other concerns identified. 3. All staff re-educated on Abuse policy and IN guidelines for reporting same. Executive Director stressed the importance of reporting immediately. 4. Executive Director and Nursing Director will conduct at least 6 monthly interviews with residents to ensure compliance with abuse protocol and reporting. Any non-compliance identified will be discussed in monthly Quality Assurance meeting x 6 months.	

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	on 4/10/2023 at 10:00 a.m. Diagnoses included hypertension and dementia. The resident resided on the secured memory care unit. No interventions were put into place to prevent recurrence. 2. During an interview on 4/10/2023 at 12:38 p.m., LPN 2 indicated on 4/7/2023, she witnessed Resident C and Resident G in bed together. Both residents were dressed. LPN 2 notified the Assistant Director of Nursing but did not notify the Administrator. The clinical record for Resident G was reviewed on 4/11/2023 at 3:43 p.m. Diagnoses included dementia with behaviors and Alzheimer's Disease. The resident resided on the secured memory care unit. No interventions were put into place to prevent recurrence. During an interview on 4/10/2023 at 12:09 p.m., with the Assistant Director of Nursing (ADON), Director of Nursing and a family member of Resident B, the family member indicated they had not been notified by the facility when Resident B and Resident G had been found in bed together. The ADON indicated she had received a text from LPN 2 on 4/8/2023 indicating the residents had been found in bed together. No one reported the incident to the Administrator. The facility did not initiate an investigation, nor was the incident reported to the state agency. During an interview on 4/11/2023 at 4/11/2023 at 12:38 p.m., LPN 2 indicated on 4/7/2023 Resident C and Resident G were found in Resident G's bed together. The residents were separated and Resident G's door was locked. LPN 2 could not remember if she reported the incident to the ADON. On 4/8/2023 LPN 2 indicated she text the			

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	ADON and was instructed to place Resident C on 15 minute checks. On 4/9/2023, Resident B repeatedly attempted to go into Resident G's room. LPN 2 indicated she had notified the ADON, but not the Administrator. A current policy, dated November 2019, titled "Abuse Non-Tolerance of Resident Policy" was provided by the Administrator on 4/10/2023 at 10:29 a..m. The policy indicated the following: "Background Statement...The Community strives to maintain a work and living environment that is free from abusive behavior consistent with the Community Mission and values. Residents and clients must be free from abuse by anyone, including Community associates, other residents or clients, consultants or volunteers, associates from outside agencies, family members or legal guardians, friends or other individuals...." This state residential finding relates to complaint IN00402597.			
R 0053 Bldg. 00	410 IAC 16.2-5-1.2(w) Residents' Rights - Deficiency (w) Residents have the right to be free from verbal abuse. Based on interview and record review, the facility failed to prevent the verbal abuse and intimidation of a cognitively impaired resident by staff members for 1 of 3 residents reviewed for abuse. (Resident C, LPN 2, and Agency CNA 4) Findings include: The clinical record for Resident C was reviewed on 4/10/2023 at 10:00 a.m. Diagnoses included hypertension and dementia. The resident lived on the secured memory care unit.	R 0053	1. Agency C.N.A. asked to leave facility immediately upon hearing the conversation. Resident C was seen by Nurse Practitioner and started on new medication. Resident G interviewed and wanted her apartment door locked. Family notified and agreed with plan. 2. Memory Care Director called all residents families to ask about any concerns related to abuse.	05/01/2023

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	During a confidential interview, Employee 3 indicated on the weekend of 4/7/2023, Resident C was walking with Resident G and they went to Resident G's room. Agency CNA 4 was observed yelling in Resident C's face. Agency CNA 4 told the resident he was going to call the police and he was not allowed to enter other resident's rooms. Agency CNA 4 told the resident they were inappropriate. On 4/8/2023, there was no inappropriate interactions between the agency CNA and Resident C. However, the agency CNA had been assigned to the care of Resident C, and the resident became irritated when the agency CNA was around. Employee 3 reported the concern to QMA (Qualified Medication Assistant) 5 who called the Director of Nursing (DON). Employee 3 indicated they did not realize the interaction between the agency CNA and Resident C was abuse, and did not report it to the Administrator. During the same weekend, LPN 2 was observed pointing their finger in the resident's face and telling the resident to back up from her, and that the resident was inappropriate. LPN 2 was over heard calling the resident a bully. The employee did not report the concern to the Administrator. During a confidential interview, Employee 5 indicated on the weekend of 4/7/2023, Agency CNA 4 was aggressive and intimidating towards Resident C. Employee 5 indicated they attempted to intervene, but the Agency CNA refused. LPN 2 was talking with a family member and Resident C had approached them. LPN 2 pointed her finger at Resident C and told them to back away and called the resident a bully. LPN 2 asked another staff member to assist with getting music on her phone and began playing the music loudly, which caused Resident C to become more agitated.		No other concerns identified. Executive Director and Nursing Director interviewed other interviewable residents on Memory Care and no other concerns identified. 3. Executive Director called the staffing agency and informed them that C.N.A. was not allowed to work at Sugar Fork Crossing going forward. All staff re-educated on Abuse protocol and IN guidelines for reporting the same. 4. Executive Director and Nursing Director will conduct at least 6 monthly interviews to ensure compliance with abuse protocol and reporting the same. Any non-compliance identified will be discussed in monthly Quality Assurance meetings x 6 months.	

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	During an interview on 4/11/2023 at 9:15 a.m., the DON indicated on 4/9/2023 at 9:08 p.m. she had received a call from the facility, indicating an agency CNA had been intimidating and verbally aggressive towards Resident C. The DON was unaware the behaviors had been happening throughout the weekend and thought it only happened just prior to the call from the facility. The DON instructed staff to remove Agency CNA 4 from the building immediately. The DON called to inform the Administrator at 9:11 p.m. During an interview on 4/11/2023 at 10:13 a.m., the Administrator indicated she received a call from the DON informing her that Agency CNA 4 had been talking to Resident C inappropriately. The Administrator indicated the staff had acted appropriately and the following day she called the agency to inform them Agency CNA 4 would no longer be allowed in their facility. The Administrator had been unaware of the concerns related to LPN 2's alleged behavior. A current policy, dated November 2019, titled "Abuse Non-Tolerance of Resident Policy" was provided by the Administrator on 4/10/2023 at 10:29 a.m. The policy indicated the following: "Background Statement...The Community strives to maintain a work and living environment that is free from abusive behavior consistent with the Community Mission and values. Residents and clients must be free from abuse by anyone, including Community associates, other residents or clients, consultants or volunteers, associates from outside agencies, family members or legal guardians, friends or other individuals...." This state residential finding relates to complaint IN00402597.			

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R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in			

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	effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on record review and interview, the facility failed report inappropriate resident to resident interactions, between cognitively impaired residents, to the appropriate state agency and responsible parties (Resident B, Resident C and Resident G). The facility also failed to ensure staff reported allegations of verbal abuse of a cognitively impaired resident by staff members, which resulted in the delay of the facility to initiate an investigation and the reporting of allegations of abuse. (Resident C, LPN 2 and Agency CNA 4). Findings include: 1. During an interview on 4/10/2023 at 12:24 p.m., the Director of Nursing (DON) indicated she had been told of an incident where Resident B was found, partially unclothed, in Resident C's room. During an interview on 4/10/2023 at 1:43 p.m., the Administrator indicated she had been informed of the incident between Resident B and Resident C immediately. The Administrator did not report the incident because the family of Resident B had indicated the resident could make decisions on sexually intimacy. The Administrator indicated she should have reported the incident. During a confidential interview, Employee 7	R 0090	1. Upon being made aware of missed reportable incident, Executive Director completed reportable incident to ISDH and opened investigation. Executive Director contacted families of Resident C and G to discuss concerns and no concerns noted. 2. Memory Care Director called all residents families to ask about any concerns with resident abuse. No other concerns identified. Executive Director and Nursing Director completed interviews with other interviewable residents on Memory Care and no other concerns identified. 3. Executive Director re-educated on Abuse protocol and IN guidelines for reporting of same. All staff re-educated on reporting suspected abuse to supervisor and/or Executive Director immediately. 4. Executive Director and Nursing Director will conduct at least 6 monthly interviews to ensure	05/01/2023

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	indicated it was reported Resident B was found in Resident C's room, and Resident B was partially dressed. During a confidential interview, Employee 1 indicated Resident B was found disrobing in Resident C's room. Employee 1 had attempted to redirect Resident B, when they became aggressive and walked through the unit, partially dressed, and returned to their own room. 2. During an interview on 4/10/2023 at 1:43 p.m., the Administrator indicated they had not been made aware of Resident C being found in bed with Resident G until 4/10/2023. Staff had not reported the incident, so the facility had not initiated an investigation. During an interview on 4/10/2023 at 12:09 p.m., with the Assistant Director of Nursing (ADON), Director of Nursing and a family member of Resident B, the family member indicated they had not been notified by the facility when Resident B and Resident G had been found in bed together. The ADON indicated she had received a text from LPN 2 on 4/8/2023 indicating the residents had been found in bed together. No one reported the incident to the Administrator. The facility did not initiate an investigation, nor was the incident reported to the state agency. During an interview on 4/11/2023 at 4/11/2023 at 12:38 p.m., LPN 2 indicated on 4/7/2023 Resident C and Resident G were found in Resident G's bed together. The residents were separated and Resident G's door was locked. LPN 2 could not remember if she reported the incident to the ADON. On 4/8/2023 LPN 2 indicated she text the ADON and was instructed to place Resident C on 15 minute checks. On 4/9/2023, Resident B		compliance with Abuse protocol and IN guidelines for reporting. Any non-compliance identified will be discussed in monthly Quality Assurance meetings x 6 months.	

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	repeatedly attempted to go into Resident G's room. LPN 2 indicated she had notified the ADON, but not the Administrator. 3. During a confidential interview, Employee 3 indicated on the weekend of 4/7/2023, Resident C had been walking with Resident G and they went to Resident G's room. Agency CNA 4 was observed yelling in Resident C's face. Agency CNA 4 told the resident he was going to call the police and he was not allowed to enter the room of other resident's. Agency CNA 4 told the resident they were inappropriate. On 4/8/2023 there was no inappropriate interactions between the agency CNA and Resident C. However, the agency CNA had been assigned to the care of Resident C and the resident became irritated when the agency CNA was around. Employee 3 reported the concern to QMA (Qualified Medication Assistant) 5 who called the Director of Nursing (DON). Employee 3 indicated they did not realize the interaction between Agency CNA 4 and Resident C was abuse and did not report it to the Administrator. During the same weekend LPN 2 was observed pointing their finger in the resident's face and telling the resident to back up from her and that the resident was inappropriate. LPN 2 was over heard calling the resident a bully. The employee did not report the concern to the Administrator. The facility did not initiate an investigation and did not report the incident to the state agency. During an interview on 4/11/2023 at 4/11/2023 at 12:38 p.m., LPN 2 indicated on weekend of 4/7/2023, Agency CNA 4 and Resident C had been aggressive with each other. LPN 2 indicated she should have, but did not chart the interaction or resident's behavior. LPN 2 did not report the incidents to the Administrator.			

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	The clinical record for Resident B was reviews on 4/10/2023 at 11:20 a.m. Diagnoses included hypothyroidism, Alzheimer's Disease, dementia and depressive disorder. The resident lived on the secured memory care unit. The clinical record for Resident C was reviewed on 4/10/2023 at 10:00 a.m. Diagnoses included hypertension and dementia. The resident lived on the secured memory care unit. The clinical record for Resident G was reviewed on 4/11/2023 at 3:43 p.m. Diagnoses included dementia with behaviors and Alzheimer's Disease. The resident lived on the secured memory care unit. A current policy, dated November 2019, titled "Abuse Non-Tolerance of Resident Policy" was provided by the Administrator on 4/10/2023 at 10:29 a.m. The policy indicated the following: "...1. Definitions ... B. "Verbal abuse" is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability... E. "Mental abuse" includes but is not limited to, verbal or non-verbal conduct which causes or has the potential to cause humiliation, intimidation, fear, shame, agitation, degradation, and threats of punishment or deprivation... 2. Prevention of Abuse ... C. Communicating and reporting concerns-Residents and families are encouraged and associates are expected to promptly communicate any problems or concerns regarding the care and treatment of residents to a			

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	supervisor. These communications may range from suggesting opportunities for team education, identifying improvements, and/or immediately reporting abuse allegations... 4. Reporting Suspected Abuse Occurrences ... B. Team Members and Volunteers must report suspected or actual abuse, preferably to their supervisor, after they make an effort to intervene to stop the abuse. Any gross mismanagement of residents that are suspected or witnessed to be abuse, neglect, involuntary seclusion, or misappropriation of resident property, will result in immediate suspension of the alleged abuser(s) pending further investigation... 5. Investigating Abuse Occurrences ... B. The senior staff member on duty initiates an investigation immediately and notifies the Executive Director and AL Director ...." This state residential finding relates to complaint IN00402597.			