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	09/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00416961. Complaint IN00416961 - State deficiencies related to the allegations are cited at R0248. Survey date: September 20, 2023 Facility number: 014080 Residential Census: 89 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed September 22, 2023.	R 0000	This Plan of Correction is submitted under regulations applicable to Long Term Care provider. The 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 of the deficiencies are correctly applied. Submission of this plan is evidence of compliance.	
R 0248 Bldg. 00	410 IAC 16.2-5-4(f) Health Services - Deficiency (f) The facility shall have available on the premises or on call the services of a licensed nurse at all times. Based on interview and record review the facility failed to provide assessment by a licensed nurse for cognitively impaired residents (Resident C and Resident D) after a resident to resident physical altercation for 2 of 4 residents reviewed for abuse. Findings include: 1. The clinical record for Resident C was reviewed on 9/20/2023 at 11:57 a.m. Diagnoses included Alzheimer's disease, dementia, and hypertension. The resident was living on the secured memory	R 0248	1 Vital signs were completed on resident D at time of incident and were within normal limits. Resident had no visible sign or symptoms of injury. Resident C was seen in follow-up by Resident's Health Care Provider and adjusted Resident's medications. 2 Current community licensed staff shall be re-educated by Health and Wellness Director	10/20/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Susan Waymire	Executive Director	10/05/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	care unit. Review of the facility reportable, dated 9/6/2023, indicated the Resident C was kicked by another resident, resulting in a fall. Review of progress notes, dated 9/6/2023 through 9/7/2023, indicated the record lacked a physical assessment of the resident after the fall. The clinical record lacked documentation of the incident and resulting fall. During an interview on 9/20/2023 at 3:08 p.m., the Director of Nursing (DON), indicated the charge person (QMA 1) never initiated an incident report for the incident. There should have been an incident report. The DON ran a report every morning that flagged incident reports. Since there was no incident report, she had been unaware of the altercation and resulting fall. During an interview on 9/20/2023 at 10:39 a.m., QMA 1 indicated they were not on the unit at the time of the altercation, but had received a report when he returned. Resident C was kicked by another resident and fell. The QMA did not initiate an incident report. The nurse working outside the memory care unit had been called to come and assess another resident that had fallen around the same time. QMA 1 was not sure if the nurse assessed Resident C. During an interview on 9/20/2023 at 12:01 p.m., LPN 2 indicated she had been called to the memory care unit to assess another resident after a fall. She had been informed of the incident, but did not assess Resident C. During an interview on 9/20/2023 at 2:12 p.m., QMA 1 indicated it was out of his scope of		regarding Incident follow-up assessments being completed timely upon notification of the occurrence of an incident. If a Nurse is not present in the community at time of an incident, the nurse on-call shall be contacted to communicate verbal instructions for immediate care. Upon return to the community, a Nurse will complete physical assessment of the affected party(ies) timely. 3 Health & Wellness Director/designee will complete 6 monthly audits of random incidents to ensure compliance with assessments as appropriate x 3 months. 4 During monthly Quality Assurance meetings, Health & Wellness Director / Designee will bring results of any non-compliance x 3 months. If 100% compliance is achieved, audits will be discontinued.	

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	practice to assess residents, but he made sure the resident's vitals were within normal limits and he did not see any skin tears. QMA 1 was uncertain if the hospice nurse, who arrived on the unit around 3:30 p.m., had assessed the resident or not. During an interview on 9/20/2023 at 2:23 p.m., the Hospice RN indicated Resident C was not her resident and she did not assess her. 2. The clinical record for Resident D was reviewed on 9/20/2023 at 1:54 p.m. Diagnoses included dementia with agitation, hyperlipidemia, and hypertension. The resident lived on the memory care unit. Review of a facility reportable, dated 9/17/23, indicated on 9/17/2023 at 11:01 p.m., Resident D had been struck in the face by another resident. The clinical record lacked any documentation of a physical assessment after the altercation. During an interview on 9/20/23 at 3:32 p.m., CNA 3 indicated she had been leaving a resident's room and observed Resident D being struck in the face by another resident. The residents were separated, and she reported the incident to the charge person, QMA 4. During an interview on 9/20/23 at 2:59 p.m., QMA 4 indicated CNA 3 had reported observing Resident D being struck in the face by another resident. QMA 4 indicated she looked at Resident D's face and did not see any injury. No nurse was in the facility at the time of the incident, and no nurse was called to do an assessment. QMA 4 called the Administrator and received instructions to have CNA 3 write a statement.			

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	During an interview on 9/20/23 at 3:08 p.m., the DON indicated no assessment had been done on Resident D, and no nurse was in the facility at the time of the incident. The resident should have been assessed by a licensed nurse. This state residential finding relates to complaint IN00416961.			