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	09/06/2023

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 a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00415480 and IN00415903. Complaint IN00415480 - State deficiencies related to the allegations are cited at R0216. Complaint IN00415903 - No deficiencies related to the allegations are cited. Survey dates: September 5 and 6, 2023 Facility number: 014080 Residential Census: 88 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed September 13, 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 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance Based on interview and record review, the facility failed to complete a medication self-administration assessment for a resident who self-administered medications stored in his room for 1 of 7 residents reviewed for self-administration of medications. (Resident B) Finding includes: During an interview on 9/5/23 at 7:22 p.m., QMA 4 indicated she was not aware which residents in the facility were assessed to administer their own medication and were safe to leave the medications	R 0216	1 The self- medication assessment for Resident B has been completed and will be re-evaluated monthly. 2 Current residents who self-administer medications will have a re-assessment completed, and will be re-evaluated monthly. 3 Current licensed staff will be re-educated regarding self-medication assessment policy by the community's Health and Wellness Director, as evidenced	10/11/2023

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

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	at bedside. She did occasionally leave medications at bedside. Sometimes residents requested her to leave medications at bedside. She was aware of the requirement to watch the residents take their medications, rather than leaving them in the residents' rooms. Resident B's clinical record was reviewed on 9/6/23 at 12:02 p.m. Diagnoses included essential primary hypertension, gastroesophageal reflux disease (GERD), pain, and allergies. The resident's current signed physician orders, dated 11/18/19, included the following: a. Flonase Suspension (allergy medication) 50 micrograms (mcg), two sprays in both nostrils once daily unsupervised self-administration. b. Omeprazole (GERD medication) 20 milligrams (mg) delayed release two capsules once daily, unsupervised self-administration. c. Singulair (allergy medication) 10 mg, once daily as needed, unsupervised self-administration. d. Tramadol hydrochloride (pain medication) 50 mg, every six hours as needed, unsupervised self-administration. The clinical record lacked a medication self-administration assessment. Review of the Medication Administration Record, dated September 2023, indicated the resident self-administered the above mentioned medications on the following dates: a. Flonase - 9/1/23, 9/2/23, 9/3/23, 9/4/23, 9/5/23, and 9/6/23 b. Omeprazole - 9/1/23, 9/2/23, 9/3/23, 9/4/23, 9/5/23, and 9/6/23 The service plan, dated 3/8/23, indicated the resident required assistance for medication		by completed Inservice Attendance Log retained in the community's Business Office. Health and Wellness Director and/or Designee will complete monthly audits of residents who self-administer medication x 3 months. 4 During monthly Quality Assurance meetings, Health & Wellness Director and/or Designee will bring results of any non-compliance x 3 months. If 100% compliance is achieved over this period of time, audits will be discontinued after three months.	

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	administration, ordering of medications, and communication with pharmacy. A Care Evaluation document, dated 3/8/23, indicated the resident was dependent on the care team for medication administration. The question regarding completion of a medication self-administration assessment was left unanswered. During an interview on 9/6/23 at 2:05 p.m., the DON indicated Resident B self-administered his Flonase and a few other medications. She indicated a medication self-administration assessment was not completed in March when the facility recognized assessments were missing. During an interview on 9/6/23 at 4:52 p.m., LPN 3 indicated residents stored their own medications in their rooms for self-administration when they had orders on their medications to self-administer medications. During an interview on 9/6/23 at 4:54 p.m., the DON indicated she was aware the resident kept medications stored in his room and self-administered the medications. A current facility policy, dated 7/12/23, titled "Medication Self-Administration," and provided by the DON on 9/6/23 at 4:12 p.m., indicated the following: "Policy: All resident have the right to self-administer medications upon the order of their provider within certain parameters: ... 6. The resident continues to demonstrate the ability to self-administer medications with monthly documentation of this continued ability in the electronic health record. Residents will be evaluated monthly using the self-medication assessment tool. Procedure: Written			

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	documentation in the form of a provider's order must be maintained in the resident's record. Monthly self-medication assessment will be completed in the electronic record in the evaluation tab...Upon move in, if a provider orders that the resident may self-administer, yet the self administration assessment tool indicates that the resident is not safe to self-administer, the DHW (Director of Health and Wellness) will call the provider and discuss the outcome of the assessment and request an order for qualified community staff to administer medications. The DHW will also discuss the results of the assessment with the resident & responsible party and document the conversation in the progress notes in the electronic medical record. [State specific regulations will apply.]...." This state residential finding relates to complaint IN00415480.			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on interview and record review, the facility failed to ensure a service plan was reviewed and acknowledged by the resident or resident representative for 1 of 5 residents reviewed for service plans. (Resident 27) Findings include: Resident 27's clinical record was reviewed on 9/6/23 at 10:09 a.m. Diagnoses included dementia, hypothyroidism, and anxiety disorder. The resident moved into the facility on 6/19/23. The resident had an admission Service Plan, dated 6/19/23. The clinical record lacked indication the service plan was reviewed or acknowledged by	R 0217	1 The Service Plan for Resident 27 has been updated, completed and signed by family. 2 Current resident Service Plans will be reviewed for completion and signed by resident/responsible party by stated compliance date. 3 Health and Wellness Director and Memory Care Director have been re-educated on facility Service Plan policy and Indiana regulations by the community's Executive Director. A completed Inservice Attendance Log retained demonstrating training maintained in the community's Business	10/11/2023

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	the resident or resident representative. During an interview on 9/6/23 at 1:12 p.m., the Administrator indicated the facility was not having the service plans signed by the residents or resident representatives. When the facility had a care plan meeting with the resident and/or resident representatives for service plan review, they have an attendance form signed by all participants. A current facility policy, dated 8/31/23, titled "Evaluation Guideline," provided by the Administrator on 9/6/23 at 1:08 p.m., indicated the following: " ...Guideline Interpretation and Implementation ... NOTE: State regulations supersede all company policies and guidelines. This guideline remains in effect, unless otherwise specified by state regulations ... To verify a comprehensive approach to resident care evaluations and individualized service plans [ISP], an evaluation will be performed ... ESL utilizes ...a well-rounded evaluation of the resident's condition, needs, desires, preferences, and capabilities ... the evaluation is done using a computerized tool, unless otherwise specified by state regulations ... As required by state, resident and/or Responsible Party and community must sign the completed service plan within the state-specified period of time. Signed copy of evaluation to be maintained in resident's wellness file ...."		Office. Health and Wellness Director and/or her Designee will complete monthly audits of Service Plans to ensure compliance. 4 During monthly Quality Assurance meetings, Health & Wellness Director and/or her Designee will bring results of any non-compliance. If 100% compliance is achieved over this period of time, audits will be discontinued after three months.	
R 0299 Bldg. 00	410 IAC 16.2-5-6(c)(3) Pharmaceutical Services - Noncompliance Based on record review and interview, the facility failed to follow-up on pharmacy recommendations for 5 of 7 residents reviewed. (Residents B, C, D, E, and F)	R 0299	1 Recommendations from July, 2023's Pharmacy audit have been presented and/or faxed to providers for signature, or	10/11/2023

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	Findings include: 1. Resident B's clinical record was reviewed on 9/6/23 at 12:02 p.m. Diagnoses included essential primary hypertension, gastroesophageal reflux disease (GERD), pain, and allergies. Current signed physician orders included the following: a. Flonase Suspension (allergy medication) 50 micrograms (mcg), two sprays in both nostrils once daily, unsupervised self-administration. b. Omeprazole (GERD medication) 20 milligrams (mg) delayed release, two capsules once daily, unsupervised self-administration. c. Singulair (allergy medication) 10 mg,once daily as needed, unsupervised self-administration. d. Tramadol hydrochloride (pain medication) 50 mg, every six hours as needed, unsupervised self-administration. The clinical record lacked a medication self-administration assessment. Review of the Pharmacist's Recommendation to Prescriber, dated 5/19/23, indicated the resident's most recent service plan and evaluation indicated the resident required staff to administer medications. The recommendation indicated to remove "unsupervised self-administration" from the following orders: Flonase, omeprazole, Singulair, and tramadol. The clinical record lacked a response, signature, or contraindication letter regarding the Pharmacist's recommendation and the orders remained unchanged. The Care Evaluation, dated 3/8/23, indicated the resident was dependent on the care team for medication administration. The question		consideration. 2 Responses to provider recommendations received will be reviewed by the community's Health & Wellness Director and/or her Designee. Resident orders will be updated with provider recommendations, as appropriate. 3 Pharmacy recommendations will receive follow-up from the community's Health and Wellness Director, or their designee, within 7 business days of receipt of audit results. The community's Health and Wellness Director, or their designee, will continue to follow up with providers each 7 business days, or until confirmation of provider's consideration has been received. 4 During monthly Quality Assurance meetings, Health & Wellness Director and/or her Designee will bring results of any non-compliance x 3 months. If 100% compliance is achieved over this period of time, audits will be discontinued after three months.	

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	regarding completion of a medication self-administration assessment was left unanswered. The service plan, dated 3/8/23, indicated the resident required assistance for medication administration, ordering of medications, and communication with pharmacy. 2. Resident C's clinical record was reviewed on 9/5/23 at 3:45 p.m. Diagnoses included nonrheumatic aortic valve insufficiency and paroxysmal atrial fibrillation. Current signed physician orders included the following: a. Coumadin (medication for atrial fibrillation) 4.5 mg tablet once daily. b. Clopidogrel (medication for atrial fibrillation) 75 mg tablet once daily. Review of the Pharmacist's Recommendation to Prescriber, dated 5/19/23, indicated a notification of a duplication in therapy with clopidogrel and Coumadin due to an increased risk of bleeding. The recommendation indicated to review the medication and consider discontinuation of clopidogrel. The clinical record lacked a response, signature, or contraindication letter regarding the Pharmacist's recommendation and orders remained unchanged. The service plan, dated 3/20/23, indicated the resident was on medication which caused bleeding/bruising. 3. The clinical record for Resident D was reviewed on 9/6/23 at 2:20 p.m. Diagnosis for the resident included coronary artery disease and unspecified systolic heart failure.			

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	Physician orders included the following: a. Montelukast sodium (to treat asthma) tablet 10 mg, once daily for chronic obstructive pulmonary disease (COPD). The order was dated 10/1/19, and was discontinued on 7/24/23. b. Fluticasone Propionate (a corticosteroid to reduce swelling) Suspension 50 mcg per actuation, two sprays into both nostrils two times a day for allergic rhinitis, unsupervised self-administration. The order dated 1/7/20, and was discontinued on 7/14/23. c. Symbicort (to treat COPD) Aerosol 160-4.5 mcg actuation, one inhalation, inhale orally two times a day for COPD, unsupervised self administration. The order was dated on 9/20/12, and was discontinued on 7/14/23. d. Magnesium Oxide (vitamin supplement) tablet 400 mg, once daily for vitamin supplement, unsupervised self administration. The order dated 1/20/22, and discontinued on 7/14/23. A review of the pharmacy recommendations dated 3/22/23 to the prescriber on 9/6/23 at 2:30 p.m., indicated Resident D was dependent on staff for medication administration and to change the following orders that stated "may self administer": Fluticasone, Magnesium oxide, Symbicort. A review of the pharmacy recommendation outcomes dated 5/17/23 to the prescriber, indicated "No Response" for the recommendation dated 3/22/23. A review of the pharmacy recommendation dated 5/17/23 to the prescriber, indicated Resident D was receiving Montelukast 10 mg daily. Montelukast has serious neuropsychiatric events which are highly variable but can include agitation, aggression, sleep disturbances,			

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	hallucinations, and memory impairment. Medication should be reserved for patients with inadequate response to treatment for allergic rhinitis. Please evaluate risk versus benefit and consider discontinuing. The documents lacked a prescriber's response or signature. 4. The clinical record for Resident E was reviewed on 9/6/23 at 3:30 p.m. Diagnosis for the resident included essential primary hypertension and hypothyroidism. A current physician order, dated 1/19/22, for Montelukast sodium tablet (to treat asthma) 10 mg, once daily, the order lacked an indication for use. A review of the pharmacy recommendation dated 5/17/23 to the prescriber, indicated Resident E was receiving Montelukast 10 mg daily. Montelukast has a serious neuropsychiatric events which are highly variable but can include agitation, aggression, sleep disturbances, hallucinations, and memory impairment. Medication should be reserved for patients with inadequate response to treatment for allergic rhinitis. Please evaluate risk versus benefit and consider discontinuing. A review of the pharmacy recommendation outcomes dated 7/11/23 to the prescriber, indicated "No Response" for the recommendation on 5/17/23. A review of the pharmacy recommendation dated 7/11/23 to the prescriber, indicated Resident E was receiving thyroid medication, please consider monitoring thyroid stimulation hormone (TSH) on the next lab day and every six months.			

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	The current clinical record lacked a lab order for TSH. The pharmacy documents lacked a prescriber's response or signature. 5. The clinical record for Resident F was reviewed on 9/6/23 at 11:05 a.m. Diagnoses for the resident included atrial fibrillation and hypertension. A physician's orders for the resident included nitrofurantoin macrocrystal 50 mg (antibacterial medication), one capsule daily for urinary tract infection (UTI) prophylactic. The order was dated 8/5/22 and discontinued 7/28/23. A review of Pharmacist's Recommendation to Prescriber report, dated 3/22/23, indicated Resident F had an order for Nitrofurantoin Macrocrystal 50 mg for UTI prophylaxis since August. Although no optimal duration of prophylaxis has been established, prolonged use, greater than six months of the medication has been associated with interstitial pneumonitis, pulmonary fibrosis, chronic hepatitis, and neuropathy. Please perform a risk versus benefit analysis for continue use of medication at this time. The document lacked a prescriber's response or signature. During an interview on 9/6/23 at 10:05 a.m., the DON indicated she had not seen any pharmacy recommendations in the last six months. During an interview on 9/6/23 at 11:38 a.m., the DON indicated the pharmacist had reviewed the residents' medications every 60 days and she would be able to provide the documented			

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	recommendations for March, May, and July of 2023, but the pharmacy recommendations had not been provided or reviewed by the physicians for at least six months. During an interview on 9/6/23 at 4:00 p.m., the DON indicated she had not provided the facility-wide pharmacy recommendations to the providers because she did not recognize they were emailed to her over the last six months. The last time she worked at the facility they were sent to her in a yellow envelope. She had been employed since 1/30/23. During an interview on 9/6/23 at 4:10 p.m., the Administrator indicated the facility lacked a policy regarding pharmacy recommendations.			
R 0302 Bldg. 00	410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency Based on observation and interview, the facility failed to label over-the-counter medications brought into the facility by resident families for 4 of 49 residents whose medications were administered by facility staff. (Medication carts AL1 and AL2) Findings include: 1. On 9/6/23 at 3:48 p.m., during observation of the Assisted Living 2 medication cart with QMA 4, the following was observed: a. Two bottles of Vitamin D3 2000 IU (international units) (supplement) lacked a resident's name, room number, and physician's name. b. Two bottles of CoQ10 200 mg (milligram) (supplement) lacked a resident's name, room	R 0302	1 Med carts 1 & 2 have been reviewed by Health & Wellness Director and/or her Designee to ensure all OTC medications have been properly labeled. 2 The remaining Med Carts in community have also been reviewed by Health & Wellness Director and/or her Designee to ensure proper labeling for all OTC medications. 3 Monthly audits of Medication carts will be completed by Health & Wellness Director and/or her Designee to ensure proper labeling of all OTC medications. Re-education will be completed prior to compliance date with all Licensed staff and Qualified	10/11/2023

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	number, and physician's name. c. A bottle of Kelp 150 mcg (microgram) of Natural Iodine (supplement) lacked a resident's name, room number, and physician's name. d. A bottle of Centrum Silver 50+ (supplement) lacked a resident's name, room number, and physician's name. e. A bottle of Calcium 600 mg plus Vitamin D3 20 mcg (supplement) with a first name written on the cap of the bottle. The bottle lacked a room number and physician's name. f. A bottle of Vitamin E 400 IU (supplement) with a resident's first and last name written on the cap of the bottle. The bottle lacked a room number and physician's name. g. A bottle of Vitamin D3 1000 IU with a first name and last initial written on the cap of the bottle. The bottle lacked a room number and physician's name. h. A bottle of Garlic Extract 1000 mg (supplement) lacked a resident's name, room number, and physician's name. i. A bottle of omeprazole 20 mg (to treat acid reflux) lacked a resident's name, room number, and physician's name. 2. On 9/6/23 at 3:58 p.m., during observation of the Assisted Living 1 medication cart with QMA 5, the following was observed: a. A bottle of D3 1000 IU lacked a resident's name, room number, and physician's name.		Medication Aides regarding OTC labeling of medications by the community's Health and Wellness Director. A completed Inservice Attendance Log retained demonstrating training maintained in the community's Business Office. 4 During monthly Quality Assurance meetings, Health & Wellness Director and/or her Designee will bring results of any non-compliance x 3 months. If 100% compliance is achieved over this period of time, audits will be discontinued after three months. (See attachment)	

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	During an interview on 9/6/23 at the time of observation, the DON indicated the over-the-counter medications brought in by family should have a label applied to them containing the resident's name, room number, physician's name, directions and date. A current facility policy, revised 7/21/23, titled, "Medication Management," provided by the DON on 9/6/23 at 4:05 p.m., indicated the following: "...Guideline Interpretation and Implementation...13. All non-prescription medications will be labeled with the resident's full name and apartment number or as required by the state regulatory requirements...."			
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance Based on record review and interview, the facility failed to ensure an admission tuberculin (TB) skin test was completed for 1 of 7 residents reviewed for admission TB testing. (Resident 27) Findings include: The clinical record for Resident 27 was reviewed on 9/6/23 at 10:09 a.m. Diagnoses included dementia, hypothyroidism, and anxiety disorder. The resident had a move-in date of 6/19/23. The immunization record in the electronic health record indicated "No immunizations found." A physician's order, dated 6/20/23, Tuberculin solution 5 Unit/0.1 ml (milliliter), inject 0.1 ml intradermally (just under the top layer of skin) one time for TB screening, first step. The electronic medication administration record (eMAR) lacked an entry of administration for the	R 0410	1 Upon review of the clinical record for Resident #27, it was discovered that a skin TB test was administered on 6-21-23, however it was not documented in the immunization record section of eMAR. Results were negative. 2 Current residents will have annual TB screening completed by the Health & Wellness Director and/or her Designee. New admissions will have the 1st and 2nd step TB skin test completed, as appropriate. 3 Licensed staff and PPD-certified Qualified Medication Aides will be re-educated on skin TB test administration for new admissions by the community's Health and Wellness Director. A completed Inservice Attendance	10/11/2023

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	09/06/2023

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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	ordered TB screening on 6/20/23. During an interview on 9/6/23 at 4:26 p.m., the Administrator indicated Resident 27 was not screened for TB. The facility lacked a policy regarding TB skin testing or screening. No further information was provided by the facility.		Log retained demonstrating training maintained in the community's Business Office. New admissions will be audited by Health & Wellness Director and/or her Designee to ensure compliance. 4 During monthly Quality Assurance meetings, Health & Wellness Director and /or her Designee will bring results of any non-compliance x 3 months. If 100% compliance is achieved over this period of time, audits will be discontinued after three months.	
R 0412 Bldg. 00	410 IAC 16.2-5-12(i) Infection Control - Noncompliance Based on record review and interview, the facility failed to develop and implement policies and procedures for prevention of tuberculosis for 3 of 7 residents reviewed (Residents B, D, and E). This deficiency had the potential to affect 88 of 88 residents who resided in the facility. Findings include: 1. The clinical record for Resident B was reviewed on 9/6/23 at 12:02 p.m. He admitted to the facility on 9/25/19 and his diagnosis included essential primary hypertension and gastroesophageal reflux disease. His last tuberculosis (TB) test was dated 7/31/22. The clinical record lacked a current tuberculosis skin test or annual risk assessment. A current order, dated 10/1/19, included tubersol solution (a skin test used for detection of tuberculosis) inject 0.1 milliliters intradermally.	R 0412	1 Current residents have had annual TB screenings completed. 2 Current residents will receive an annual TB assessment on an ongoing basis, per regulation. 3 Current Licensed staff will be re-educated on Annual TB screening assessments by the community's Health and Wellness Director. A completed Inservice Attendance Log retained demonstrating training maintained in the community's Business Office. Health & Wellness Director and/or her Designee will complete monthly audits of new admissions to ensure compliance with TB administration. 4 During monthly Quality Assurance meetings, Health & Wellness Director and/or her	10/11/2023

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	09/06/2023

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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	2. The clinical record for Resident D was reviewed on 9/6/23 at 2:30 p.m. She was admitted to the facility on 1/31/18 and her diagnosis included coronary artery disease and unspecified systolic heart failure. Her last TB test was dated 7/31/22. The clinical record lacked a current tuberculosis skin test or annual risk assessment. 3. The clinical record for Resident E was reviewed on 9/6/23 at 3:30 p.m. She was admitted to the facility on 1/19/22 and her diagnosis included essential primary hypertension and hypothyroidism. Her last TB test was 1/19/22, upon admission. The clinical record lacked a current tuberculosis skin test or annual risk assessment. During an interview with the DON on 9/6/22 at 2:38 p.m., she indicated another employee kept track of the annual TB schedule, which included annual risk assessments. She was unable to locate the annual TB testing schedule. The DON indicated that residents D and E should have received a TB test or risk assessment already this year and she did not know why they had not. Current management personnel were trying to get a process or program in place that allowed for all residents to be reviewed and tested in the same month to prevent missing any. During an interview with the Administrator on 9/6/23 at 4:10 p.m., she indicated the facility had no policy related to tuberculosis screening or testing.		Designee will bring results of any non-compliance x 3 months. If 100% compliance is achieved over this period of time, audits will be discontinued after three months. (See attachment)	