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	08/03/2023

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 Complaint IN00411689. Complaint IN00411689 - State deficiencies related to the allegations are cited at R0052. Unrelated deficiency is cited at R0090. Survey date: August 3, 2023 Facility number: 014080 Residential Census: 87 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed August 7, 2023.	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 of the deficiencies are correctly applied. Submission of this Plan is evidence of compliance.	
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 the elopement of 1 of 3 cognitively impaired residents reviewed for elopement, by failing to monitor visitors during a resident move-in. (Resident A) This deficient practice resulted in 1 cognitively impaired resident being found, unsupervised, in front of the facility and had the potential to affect 36 of 36 cognitively	R 0052	1. The resident's care plan has been updated to reflect the elopement and intervention put in place for enhanced safety. 2. All residents assessed for elopement risk and care plans updated as appropriate.	08/25/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Susan Waymire	Executive Director	08/15/2023

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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	impaired residents living on the Memory Care unit. Finding includes: The clinical record for Resident A was reviewed on 8/3/23 at 1:49 p.m. Diagnoses included dementia and hypertension. Review of a facility reportable, dated 6/27/2023 at 12:44 p.m., indicated Resident A had eloped from the secured facility when a family member let him out the door while moving a new resident into the facility. Another visitor, who recognized Resident A seated on a bench in front of the facility, notified the staff at the front desk. The resident was returned to the secured unit. The resident was placed on 15 minute checks for 24 hours. A nursing progress note, dated 6/27/23 at 1:15 p.m., indicated the resident was seated on front porch of the facility for approximately 20 minutes. He was dressed appropriately for weather and was returned safely inside without incident. The resident's son and the Administrator were notified. During an interview on 8/3/23 at 9:50 a.m., the DON indicated she was not in the building when the elopement occurred. A new resident's family was moving her in and had the back door open and Resident A was allowed to walk out. During an interview on 8/3/23 at 10:12 a.m., the Memory Care Director indicated a family member was moving a resident in and when the family member went out the side door, Resident A was behind him and walked out with him. The family member later told her he was in a hurry and had not realized Resident A was a resident. There was		3. Staff re-educated on elopement procedures. All new families for Memory Care residents will be educated on move-in/move-out protocol upon admission. All new admissions for Memory Care will be assessed for elopement and care planned as appropriate. 4. Monthly audits for residents at risk for elopement will be reviewed and updated as needed. Any updates will be brought to Monthly Quality Assurance meetings and reviewed x 6 months. If no non-deficient practices identified audits will be discontinued at the end of 6 months.	

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	no policy regarding the procedure for when resident's families move in new residents. It was impossible for staff to watch the door the whole time of the move. She was unaware of any family education that occurred when a new resident was admitted to the Memory Care unit. During an interview on 8/23/23 at 10:36 a.m., the Administrator indicated families were educated during the contract signing process regarding resident safety, but had not spoken to families specifically regarding letting someone out when they exit the unit. She was notified of the elopement and reviewed the camera footage. The resident went out the door at 12:44 p.m. and was returned to the unit at 1:08 p.m., or in 24 minutes. A visitor who happened to recognize Resident A, notified staff that he was outside sitting on a bench. The facility had no policy and procedure for resident move in or move out. This state residential finding relates to complaint IN00411689.			
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:			

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	(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 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 to report resident-to-resident abuse to the Indiana State Board of Health. (Residents B and D) Findings include:	R 0090	1. Executive Director re-educated on Indiana reportable incident guidelines. 2. Resident and/or families interviewed for any concerns	08/25/2023

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	1. The clinical record for Resident B was reviewed on 8/3/23 at 1:49 a.m. Diagnoses included dementia, hearing loss and hypertension. An incident note, dated 6/16/23 at 4:50 a.m., indicated staff had witnessed Resident D hitting Resident B in the face with a blanket that Resident B was covering himself with. The repetitive hitting caused Resident B's glasses to bend, and hit his upper left brow resulting in a small skin tear. Staff indicated they felt the incident occurred due to Resident B's "incessant hollering" to go home. 2. The clinical record for Resident D was reviewed on 8/3/23 at 1:20 p.m. Diagnoses included Alzheimer's disease. A nursing note, dated 6/16/23 at 10:26 a.m., indicated the resident's wife had been notified of the altercation the resident had with another resident earlier in the morning. The physician had been notified. During an interview on 8/3/23 at 12:28 p.m., the Administrator indicated she had not reported the resident-to-resident incident due to lack of intent. She reviewed the camera footage and Resident D would have hit any resident that was in his way. He wanted Resident B's blanket and the incident had no personal intent. It had not appeared that the resident actually hit Resident B. She had made the determination not to report the incident, but had not reviewed the incident note in the medical record. She should have reported it to the Indiana Department of Health (IDOH). The Administrator indicated she used the "Indiana State Department of Health, Incident Reporting Policy." Review of the current document, dated 12/8/23, indicated the following: "...II. RESIDENTIAL CARE FACILITIES...410 IAC		related to abuse. 3. Staff re-educated on abuse policy and reporting of any concerns identified. 4. Monthly interviews with at least 6 residents and/or families will be conducted x 6 months. Any non-compliance identified will be brought to monthly Quality Assurance Meetings for review. At the end of 6 months interviews will be discontinued if no new non-compliance identified.	

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	16.2-5-1.3(g)(1) states: 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...."			