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	01/28/2025

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 IN00450661. Complaint IN00450661 - State deficiencies related to the allegations are cited at R0041. Survey date: January 27 and 28, 2025 Facility number: 014080 Residential Census: 104 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed February 4, 2025.	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 0041 Bldg. 00	410 IAC 16.2-5-1.2(o)(4) Residents' Rights - Deficiency Based on interview and record review, the facility failed to conduct a thorough investigation of an allegation of abuse involving cognitively impaired residents for 2 of 4 residents reviewed for abuse. (Residents B and C) Findings include: The clinical record for Resident B was reviewed on 1/28/24 at 11:14 a.m. Diagnoses included dementia, anxiety, hypertension, hypothyroidism, and macular degeneration. A physician order, dated 6/25/23, indicated the	R 0041	The regional nurse immediately assessed resident B for injury completed on 1/28/25. The regional nurse and regional memory care director began reviewing all MC residents for sexual behaviors and ensured appropriate interventions were care planned in residents' service plan, this began on 1/28/25 and was completed on 2/05/25. The regional nurse assigned all directors in the community how to conduct an	03/01/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lorena Glover	Executive Director	02/24/2025

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	resident was started on Paxil (antidepressant) for sexually inappropriate behaviors. Review of progress notes, dated 12/2/24 to 1/7/25, lacked documentation of sexually inappropriate behaviors. A progress note, dated 1/4/25 at 6:56 p.m., indicated Resident B's visitor went to resident's room and found a male resident in the room, sitting on the edge of the bed, with no clothes on from the waist down. Staff assisted the male resident in putting on his clothing and redirected him to his room. The clinical record lacked assessment of Resident B for injury. A facility reportable incident document sent to IDOH, dated 1/4/25 at 6:23 p.m., indicated Resident C was found sitting on the edge of Resident B's bed, naked from the waste down. Resident B was fully clothed. A current service plan, dated 1/7/25, indicated Resident B had safety concerns and required a safety check every 2-3 hours. The resident had sexually inappropriate behaviors. Interventions included staff to report any changes from baseline behaviors. The resident's cognition was mild to moderate disorientation with difficulty retaining or recalling information. The resident also displayed deficits in judgement. The clinical record for Resident C was reviewed on 1/27/25 at 11;43 a.m. Diagnoses included, dementia and anxiety. Review of progress notes, dated 10/16/24 through 1/16/25, indicated the resident's behaviors as		abuse investigation training, this will be completed by 3/01/25. All staff completed abuse and neglected training on 12/26/2024. Focusing on the importance of reporting abuse immediately to the supervisor. All Staff Abuse and neglect training will be completed at the all staff meeting on 02.27.2025 focusing on the importance of reporting abuse immediately to the supervisor Going forward DHW/MCD or designee will review all documentation in nursing notes, any documentation of abuse and immediately report findings to the Executive Director who will begin an investigation.	

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	follows: 10/29/24 at 8:07 p.m.: Resident attempted to lift and care for women on the unit. The resident attempted to make female residents go to bed and became mad at staff for not making the female residents go to bed. The resident was no redirected easily. 11/2/24 at 7:09 p.m.: Resident attempted to pick residents up from their wheelchairs and help them to bed. Staff explained to resident that staff would assist residents with transfers. The resident was not easily redirected. Resident in female resident rooms attempting to help them to bed. 11/13/24 at 2:04 p.m.: Staff observed resident watching female resident rooms that had the door open. When resident realized staff were observing him, he started interacting with other male residents. Staff walked away and tuned to see the resident was no longer in the area. The resident was found in female resident's room attempting to close the door. Staff member intervened and redirected resident from the room. 12/24/24 at 6:58 p.m.: Resident observed attempting to transfer another resident from recliner. Staff redirected and assisted other resident into wheelchair. Resident stated "I need to get her up". Staff explained to resident he was not to assist residents with transfers due to safety concerns. 12/27/24 at 3:51 p.m.: Staff observed resident standing over a female resident who was laying on a couch in the common area. The resident was re-directed. 12/27/24 at 5:30 p.m.: The resident was observed			

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	assisting a female resident with her walker. The female resident did not want assistance. Staff intervened and redirected resident. 1/4/25 at 6:36 p.m.: Staff reported finding resident in a female resident's room with no clothes from waste down. Staff assisted resident in putting his clothing back on and redirected to his room. Staff reported that resident stated he was going to "make love." Staff stated that resident was unaware that female resident was not his wife. 1/20/25 at 8:16 a.m.: The resident was observed attempting to take a female resident to her room. Redirection was attempted. When staff returned to the area the resident had pushed the female resident back to her room. The resident was redirected back to his room. Review of a current service plan, dated 1/22/25, indicated Resident C had cognitive impairment with mild to moderate disorientation with difficulty retaining or recalling information. The service plan lacked indication of, or interventions for, sexual behaviors or behaviors focused on female residents. During an interview on 1/27/25 at 10:51 a.m., the Administrator indicated the facility investigations were located in the resident chart. No staff interviews or resident assessments were done or provided. Staff education provided was dated 11/4/24 and 12/26/24. The Administrator indicated the facility did not need to do resident assessments or interviews for a resident-to-resident altercation. During an interview on 1/28/25 at 12:35 p.m., the psychiatric NP indicated she was unaware of any overt sexually inappropriate behaviors since the			

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	resident was started on Paxil. She indicated the resident could be "flirty" at times and confused male residents with her ex-husband. During an interview on 1-27-25 at 3:13 p.m., a family member for Resident B indicated, on the evening of 1/4/25, they entered the resident's room and found Resident B and Resident C lying across the bed. Resident C was naked from the waist down. A current policy, dated 11/1/23, titled :Abuse & Neglect Reporting Policy". This policy was provided by the Administrator on 1-27-25 at 11:53 a.m. The policy indicated the following: " .... Procedure .... Allegation of acts that could be considered abusive, neglectful, or exploitative shall be reported to the community's state regulatory authority, in accordance with state regulations. If the allegation involves a resident, reports shall be made to the resident's healthcare provider, and the resident's responsible party. The community's Executive Director will conduct an investigation of the allegation to include, but not limited to: Date and time that the notification had occurred Date investigation started Record of statements or interviews of involved parties. Documentation pertaining to the incident If an injury was sustained due to the incident, the examination report(s) of parties involved Documentation of steps taken to protect individual(s) from future harm, as available Interventions and/or corrective actions implemented, as applicable ...." This citation relates to Complaint IN00450661.			