DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

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	12/13/2023

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 IN00423437, IN00423379, and IN00422337. Complaint IN00423437 - State deficiencies related to the allegations are cited at R0406. Complaint IN00423379 - No State Residential Findings related to the allegations are cited. Complaint IN00422337 - State deficiencies related to the allegations are cited at R0216. Survey dates: December 12 and 13, 2023 Facility number: 014080 Residential Census: 82 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed December 20, 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 (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Susan Waymire	Executive Director	01/05/2024

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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	self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to provide semi-annual assessments and change in condition assessments for 1 out of 5 residents reviewed for assessments. (Resident B) Findings include: The clinical record for Resident B was reviewed on 12/12/23 at 11:45 a.m. Diagnoses include dementia, anxiety disorder, and hypothyroidism. Review of a progress note, dated 11/18/23 at 9:06 p.m., indicated the resident stood up from the wheelchair and fell. The resident landed on their bottom. The resident was assessed and no injuries were noted. They denied pain. Review of a progress note, dated 11/19/23 at 4:07 p.m., indicated the resident complained of right hip pain. A STAT right hip x-ray was obtained and showed a right hip fracture. Review of a progress note, dated 11/20/23 at 10:51 a.m., indicated the resident was transferred to the hospital for evaluation and treatment. Review of a progress note, dated 11/20/23 at 2:04 p.m., indicated the resident returned to the facility. Review of a progress note, dated 11/21/23 at 10:47 a.m., indicated the resident was admitted to hospice care. Review of the "Morse Fall" risk assessment, dated 10/16/23 at 12:19 p.m., indicated the resident was a high risk for falls.	R 0216	1 The change in condition assessment for Resident B has been completed by the Memory Care Director on 12-14-2023 and will be reassessed semi-annually or change in condition as needed. 2 Current residents have been reviewed and assessments are current per regulatory requirements. 3 Health and Wellness Director and Memory Care Director have been re-educated on policy for resident assessments by Executive Director on 01-03-2024. 4 Health and Wellness Director and/or designee shall complete monthly audits x 3 months to ensure compliance. During monthly Quality Assurance meetings, Health and Wellness Director and/or designee will bring results of any non -compliance x 3 months. If 100% compliance is achieved, audits will be discontinued.	01/12/2024

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	Review of the "Morse Fall" risk assessment, dated 11/22/23 at 10:16 a.m., indicated the resident was a high risk for falls. During an interview on 12/13/23 at 12:49 p.m., the Director of Nursing indicated the resident should have had a change in condition assessment after being admitted to hospice and a semi annual assessment. Neither the change of condition nor the semi-annual assessment were documented in the clinical record. Review of a current facility policy, dated 1/25/23, titled "Evaluation Guideline", and provided by the DON on 12/13/23 at 1:10 p.m., indicated the following: ".... Six-month evaluations will be completed for each resident every six months going forward after move-in, provided there are no significant changes of condition .... Change of Condition evaluations will be completed when a resident sustains a significant change of condition, or a change in required/requested services. ...." This citation relates to Complaint IN00422337.			
R 0406 Bldg. 00	410 IAC 16.2-5-12(a) Infection Control - Offense (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection.			
	Based on observation, record review, and interview, the facility failed to ensure staff practiced appropriate infection control protocols for 4 of 5 residents reviewed for isolation. (Residents E, F, G, and H)	R 0406	1 No residents were found to be adversely affected by the trash cans being on the outside of apartment doors. Upon being	01/12/2024

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	Finding include: During an observation on 12/12/23 from 9:23 a.m. through 9:40 a.m., the following was observed: Resident E's room and Resident F's room each had signage to indicate isolation for COVID-19, and had trash containers with discarded Personal Protective Equipment (PPE) in the hallway. Resident G's room and Resident H's room each had no signage on the doors to indicate isolation. There were trash containers with discarded PPE in the hallway. During an interview on 12/12/23 at 10:26 a.m., QMA 1 indicated PPE was removed after exiting the room and placed in the trash container located outside the room in the hallway. During an interview on 12/12/23 at 10:44 a.m., the DON indicated staff were in-serviced on the donning and doffing of PPE. The DON provided isolation signage used for staff inservice. The signage instructions indicated for PPE to be removed before exiting the room. Another instructional sheet used for staff in-servicing titled "How to safely Remove Personal Protective equipment (PPE) Example 2" indicated all PPE was to be removed before exiting the resident's room. During an interview on 12/12/23 at 10:49 a.m., CNA 2 indicated PPE was removed after exiting the room and placed in the trash container located outside the room in the hallway. During an interview on 12/12/23 at 11:13 a.m., CNA 3 indicated PPE was removed after exiting the room and placed in the trash container located		made aware the cans were moved immediately to the inside of apartment. PPE and signage procedures have been updated to utilize appropriate infection control processes. 2 Staff re-educated on Infection Control protocols for Covid-19 by Health and Wellness Director. Team members are trained upon hire and annually of Infection Control practices by Health and Wellness Director and/or her designee. 3 In the event of residents needing isolation, the community's Health and Wellness Director and/or her designee and community Executive Director and/or her designee will complete daily checks to ensure appropriate infection control processes are being followed. 4. During monthly Quality Assurance meetings, Health and Wellness Director will bring results of any non-compliance x 6 months. If 100% compliance is achieved, this will be discontinued.	

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	outside the room in the hallway. During an interview on 12/12/23 at 11:45 a.m., the Director of Nursing (DON) indicated the four residents had current COVID-19 infections. The trash containers for the isolation rooms should be located inside the rooms, and signage should have been posted outside of the rooms of those with COVID-19. During an interview on 12/12/23 at 2:25 p.m., CNA 4 indicated PPE was removed after exiting the room and placed in the trash container located outside the room in the hallway. This citation relates to Complaint IN00423437.			