STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/28/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intake IN00465486. Intake IN00465486- State deficiencies related to the allegations are cited at R0349. Survey date: October 27 and 28, 2025 Facility number: 014080 Residential Census: 100 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed November 3, 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 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained	R 0349	**Documentation of blood sugar readings have been added to Resident D's chart, and have been verified as of 11/14/2025. The community's medication**	12/01/2025

under the supervision of an employee of the facility designated with that responsibility. The records must be as follows:

(1) Complete.

(2) Accurately documented.

(3) Readily accessible.

(4) Systematically organized.

Based in record review and interview, the facility failed to ensure necessary medication administration and related medical monitoring were documented in the resident's clinical record to ensure complete and accurate records necessary to provide required health services for 3 of 3 residents reviewed for complete and accurate clinical records (Residents B, C, and D).

Findings include:

1. Resident B's clinical record was reviewed on 10/27/25 at 1:00 p.m. Current diagnoses included hypertension, anxiety, and atrial tribulation.

The resident had a 9/9/25 physician's order to monitor blood pressure one time (1) daily for seven (7) days (9/9/25-9/16/25). The resident had a 9/24/25 physician's order to monitor blood pressures Monday, Wednesday, and Friday for 14 days (9/24/25 to

personnel have continued to record blood sugar readings within the resident's electronic medical record.

By December 1, 2025, the community's Wellness Nurse, or their designee, shall review current residentsorders for health monitoring effective as of October 1, 2025 to ensure that they have been transcribed and documented in accordance with the physician order in the residents electronic medical record.

The community's current Wellness Nurse(s) shall be retrained by the community's Executive Director on documentation in clinical record of physician orders and health monitoring. An in-service attendance log of such retraining shall be maintained with the community's training records.

New community Wellness Nurses
shall be trained by the community's Director of Health and Wellness, or their designee, on documentation standards and orders management via the electronic health record.

The community's Wellness Nurse, or their designee, shall review clinical records for compliance with health

	10/8/25). The Medication Administration Record for September and October 2025 (10/1/25 through 10/26/25) were reviewed. The record lacked documentation of blood pressure monitoring on the following dates: 9/9/25, 9/11/25, and 9/24/25. 2. Resident C's closed clinical record was reviewed on 10/27/25 at 10:33 a.m. Discharge diagnoses included Parkinson's disease and anxiety. At the time of discharge, the resident had a 12/28/24, physician's order for carbidopa-levodopa 25/100 mg (a Parkinson's disease medication) - take one tablet 5 (five) times daily. The resident was discharged from the facility on 9/24/25. The Medication Administration Record for September 2025 (9/1/25 to 9/23/25) was reviewed. The record lacked documentation of the Parkinson's Medication being administered for the 6:00 a.m. dose on the following dates: 9/2/25, 9/5/25, 9/10/25, 9/16/25, and 9/23/25.		monitoring orders at least once weekly through February 1, 2026. Results of such observations shall be reported to the community's Executive Director, or their designee. Noncompliance findings will be immediately actioned with corresponding notifications to resident's healthcare provider and documented within the resident's electronic medical record. Additionally, noncompliance observed through the time frame shall result in continued observation for at least two more weeks, until full compliance is observed.	

3. Resident D's clinical record was reviewed on 10/27/25 at 1:15 p.m. Current diagnoses included diabetes mellitus and anxiety.

The resident had a 6/15/25 physician's order for blood sugar check every morning for the monitoring of diabetes mellitus.

The Medication Administration Record for September and October 2025 (10/1/25 through 10/26/25) were reviewed. The record lacked documentation of blood sugar monitoring on 9/1/25, 9/2/25, 9/3/25, 9/5/25, 9/6/25, 9/10/25, 9/13/25, 9/14/25, 9/15/25, 9/16/25, 9/22/25, 9/23/25, 9/24/25, 9/29/25, 10/4/25, 10/9/25, 10/14/25, and 10/21/25.

During an interview, on 10/27/25 at 2:20 p.m., the Administrator indicated due to the DON not being available, QMA 2 would answer questions regarding the nursing department and health care aspect of the facility.

During an interview, on 10/27/25 at 2:45 p.m., QMA 2 indicated she would review records for missing documentation for Resident B's blood pressure monitoring, Resident C's medication administration, and Resident D's blood sugar monitoring and provide information the next morning.

During an interview on 10/28/25 at 9:38 a.m., QMA 2 indicated the following:

Resident D's blood sugar was documented in a small notebook in her room. This information should later be documented in the clinical record and it was not.

The staff reported Resident B's blood pressures were taken during the 7 and 14 day observation period. However, the staff members who took the blood pressure failed to document the results.

She could not determine why there were blanks in Resident C's medication administration record for the 6:00 a.m. medication used to treat Parkinson's disease. The medication should have been documented when administered. The QMA who the facility believed was working those shifts had been unavailable to answer questions. Every medication should be documented in the residents medication administration record at the time it is administered.

A current facility policy, dated 8/11/23, titled "Medication Management", which was provided by QMA 2 in 10/28/25 at 9:54 a.m., indicated "Staff assisting with or administering

medication will follow the 7 rights of medication....right documentation."

A current facility policy, dated 1/6/24, titled "Basic Care Services", which was provided by the Administrator on 10/28/25 at 12:06 p.m., indicated:

"Team Member documentation of Basic Care Services shall be made in accordance with the ESL Electronic Medical Record E-Signature Guideline..."

During an interview on 10/28/25 at 12:06 p.m., the Administrator indicated the facility did not have a policy regarding complete and accurate clinical records and/or documentation.

This citation relates to Intake IN00465486.

Based in record review and interview, the facility failed to ensure necessary medication administration and related medical monitoring were documented in the resident's clinical record to ensure complete and accurate records necessary to provide required health services for 3 of 3 residents reviewed for complete and accurate clinical records (Residents B, C, and D).

Findings include:

1. Resident B's clinical record

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2. Resident C's closed clinical record was reviewed on 10/27/25 at 10:33 a.m. Discharge diagnoses included Parkinson's disease and anxiety.

At the time of discharge, the resident had a 12/28/24, physician's order for carbidopa-levodopa 25/100 mg (a Parkinson's disease medication) - take one tablet 5 (five) times daily. The resident was discharged from the facility on 9/24/25.

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(9/1/25 to 9/23/25) was reviewed. The record lacked documentation of the Parkinson's Medication being administered for the 6:00 a.m. dose on the following dates: 9/2/25, 9/5/25, 9/10/25, 9/16/25, and 9/23/25.

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURELorena Glover	TITLEExecutive Director	(X6) DATE11/15/2025