STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/19/2024

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 Complaints IN00433195 and IN00433785. Complaint IN00433195 - No deficiencies related to the allegations are cited. Complaint IN00433785 - State deficiencies related to the allegations are cited at R0217. Survey dates: 7/18/24- 7/19/24 Facility number: 014080 Residential Census: 92 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed July 26, 2024.	R 0000	regulations applicable to Long 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 the at the scope and severity regarding any of the deficiencies are correctly applied. Submission of this plan is evidence of compliance intention by 9-10-2024.	
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an	R 0217	1 Resident B moved out on 05-05-2024 home with hospice. The Health and Wellness Director and	09/10/2024

	evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.		Memory Care Director immediately audited current Resident Files for signatures on service plans and anyone not having a signature will be corrected by 09-10-2024 2 The Service Plan for Resident D has been updated, completed, and verbally acknowledged by the resident/responsible party by stated compliance date. 07-31-2024 3 The Health and Wellness Director and Memory Care Director have been re-educated on Community 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 Office. 4 Health and Wellness Director and/or her Designee will complete 5 chart audits monthly of Service Plans to ensure compliance for a period of 3 months.	

	Based on record review and interview, the facility failed to ensure service plans were signed by the resident or resident representative for 2 of 3 residents reviewed for service plans. (Residents B and D) Findings include: 1. Resident B's clinical record was reviewed on 7/18/24 at 11:05 a.m. Diagnosis included vascular dementia with behavioral disturbances and agitation. A service plan, dated 4/9/24, indicated the resident was independent with ambulation, had mild to moderate disorientation, and was a fall risk. The service plan lacked a resident or resident representative signature. 2. Resident D's clinical record was reviewed on 7/18/24 at 2:59 p.m. Diagnosis included unspecified dementia, hypertension, and restless legs syndrome. A current service plan, dated 4/17/24, indicated the resident required stand-by-assistance for mobility in her wheelchair, displays deficits in judgment, and demonstrated sexually inappropriate behaviors at times. The service plan lacked a resident or resident		5 During Monthly Quality Assurance Meetings, the Health and 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 3(three) months.	

representative signature.

During an interview, on 7/19/24 at 1:24 p.m., the DON indicated she was not able to locate signed service plans for Resident's B and D.

A current facility policy, revised on 8/31/23, titled, "Evaluation Guidelines", provided by the DON, on 7/19/24 at 1:37 p.m., indicated the following: "... 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..."

This citation is related to complint IN00433785.

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independent with ambulation, had mild to moderate disorientation, and was a fall risk. The service plan lacked a resident or resident representative signature.

2. Resident D's clinical record was reviewed on 7/18/24 at 2:59 p.m. Diagnosis included unspecified dementia, hypertension, and restless legs syndrome.

A current service plan, dated 4/17/24, indicated the resident required stand-by-assistance for mobility in her wheelchair, displays deficits in judgment, and demonstrated sexually inappropriate behaviors at times. The service plan lacked a resident or resident representative signature.

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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 SIGNATURE	TITLE	(X6) DATE