

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 014080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/09/2023
NAME OF PROVIDER OR SUPPLIER SUGAR FORK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 1745 EAST 67TH STREET ANDERSON, IN 46013		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00398724 and IN00397913.</p> <p>Complaint IN00398724 - Substantiated. No State Residential Findings related to the allegations were cited.</p> <p>Complaint IN00397913 - Substantiated. No State Residential Findings related to the allegations were cited.</p> <p>Survey date: January 9, 2023</p> <p>Facility number: 014080</p> <p>Residential Census: 95</p> <p>Sugar Fork Crossing was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00398724 and IN00397913.</p> <p>Quality review completed January 12, 2023.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE