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	09/18/2024

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 a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00441028. Complaint IN00441028 - State deficiencies related to the allegations are cited at R0064. Survey dates: September 16, 17, and 18, 2024 Facility number: 014080 Residential Census: 94 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed September 23, 2024.	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 of the deficiencies are correctly applied. Submission of this Plan is evidence of compliance.	
R 0064 Bldg. 00	410 IAC 16.2-5-1.2(hh) Residents' Rights- Noncompliance Based on record review and interview, the facility failed to ensure a cognitively impaired resident was free from misappropriation for 1 of 3 reviewed for misappropriation. (Resident B) Finding includes: A 8/14/24, facility self -reported incident indicated the following: "Brief Description of Incident": A report was made to the Director of Health and Wellness by CNA 6 and HHA 7 that a previous employee, CNA 8, had made purchases using Resident B's online retailer account. The immediate actions taken included inquiring with	R 0064	1. The community has completed a comprehensive investigation of the reported incident, inclusive of alerting local law enforcement. After receiving notice from local law enforcement that criminal charges would be sought, the community notified the Indiana Licensing Agency as to the former Team Member's involvement. 2. The resident's Responsible Party has filed a fraud claim with Amazon for reimbursement of the unauthorized purchases.	10/30/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lorena Glover	Executive Director	10/04/2024

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.

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	09/18/2024

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
	Resident B's online retailer account and confirming any purchases. The Director of Health and Wellness advised the Administrator of the incident at this time. CNA 6 and HHA 7 provided written statements. The Administrator contacted Resident B's family and the local police. Preventative measures indicated the facility would education the staff on resident rights and complete an in-service. A follow-up letter was sent to family members of the community. Resident B's clinical record was reviewed on 9/16/24 at 2:34 p.m. Diagnoses included congestive heart failure, atrial fibrillation, and polyneuropathy. A 7/25/24, "Care Evaluation and Service Plan" indicated Resident B had cognitive impairment. An 8/14/24 progress note indicated a report was made about a prior employee using Resident B's online retailer account to make purchases. An investigation was started, family notified, and a police report filed. A 3/13/24, "Resident Rights" document was signed and acknowledged by Resident B. A review of the facility investigation file, provided by the Administrator on 9/17/24 at 10:43 a.m. included the following: An 8/14/24, written statement from CNA 6 indicated she was told by a co-worker, HHA 7, that a previous employee had ordered off Resident B's online retailer account. CNA 6 checked Resident B's cellular device and saw the charges and delivery address for the previous employee.		3. The community has conducted a review of current Team Member files to ensure that results of a criminal background screen prior to their date of hire are on file. Future Team Members shall have a criminal background screen completed prior to their date of hire, and results shall be maintained within their personnel file. 4. The community's Executive Director, or their designee, shall complete a review of Resident Rights with current community Team Members. Completion of such review is anticipated no later than October 30, 2024, and shall be evidenced by Inservice Attendance Logs, to be maintained with the community's training files. 5. New community Team Members shall be oriented to Resident Rights within their new hire onboarding process. Completion of orientation shall be evidenced by Inservice Attendance Logs, to be maintained with the community's training files.	

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	09/18/2024

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
	An 8/14/24, written statement from HHA 7 indicated she was told by a co-worker that a former co-worker was ordering stuff off a resident's cellular phone and posting pictures on social media. Screen shots from Resident B's cellular phone with "Order Details" from her online retailer account, dated 7/6/24 indicated a shipping address listed was different from the Resident B's address. The address listed was connected to CNA 8, the former employee. The merchandise total was $357.74. A social media picture, dated 7/9/24, of CNA 8 with one of the possible items purchased using Resident B's online retailer account. An 8/16/24, letter to the community family and friends advising of the isolated incident. A handwritten timeline, written by the Administrator, indicated the steps taken in the investigation. A review of CNA 8's employee file, on 9/17/24 at 4:41 p.m., indicated his hire date was 5/28/24 and termination date as 7/12/24. A 7/11/24, "Employee Termination Notification" document indicated CNA 8's last worked day was 7/9/24 and the reason for termination was No Call/No Show for scheduled shifts. A 5/22/24, "Resident Rights" document, signed and acknowledged by CNA 8. A 5/22/24, "Abuse and Neglect Reporting" document, signed and acknowledged by CNA 8.			

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	09/18/2024

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
	A 9/18/24, transcript from a workforce education database indicated CNA 8 completed the following abuse and dementia trainings: "Dementia care: Normal Aging vs Alzheimer's/Dementia", completed 5/28/24. "Alzheimer's Disease and Related Disorders: ADL Care", completed 6/3/34. "Alzheimer's Disease and Related Disorders: ADL's and Behaviors", completed 6/3/24. "Alzheimer's Disease and Related Disorders: Communication Needs", completed 6/3/24. "Alzheimer's Disease and Related Disorders: Recreational Activities", completed 6/3/24. "Alzheimer's Disease and Related Disorders: The Environment", completed 6/3/24. "Preventing, Recognizing, and Reporting Abuse", completed 5/30/24. "Abuse, Neglect, and Exploitation", completed 5/28/24. During an interview, on 9/17/24 at 2:45 p.m., Resident B's family indicated the facility had contacted them about a former staff member using the online retailer account of their loved one for personal purchases. The family indicated the facility had contacted the police. The facility was investigating the incident as well. The family planned to look at additional financial records to ensure all fraudulent activity was discovered. The family was concerned since Resident B had dementia and would be extremely upset if she knew the extent of the situation. The family indicated they had been told this staff member was working at another facility. During an interview on 9/17/24 at 3:31 p.m., CNA 6 indicated she was told by HHA 7 that an ex-employee had been ordering items online from a resident's account. She went and checked the resident's phone and found the charges with a different address for the delivery. She immediately told the Director of Health and Wellness. She was			

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	09/18/2024

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
	not sure if the former employee was employed by the facility at that time. CNA 6 wrote a statement and spoke with a detective a few days ago. During an interview, on 9/17/24 at 4:01 p.m., the Administrator indicated the incident was fairly cut and dry. There was a clear path. The address matched the former employees address. She felt it was easy to ascertain the validity of the accusation. She had not reported the former employee to the license board at this time, since the police investigation was still ongoing. CNA 8 was terminated for No Call/No Show of scheduled shifts in July 2024. An undated, current facility policy, titled, " Resident Rights", provided by the Director of Heath and Wellness, on 9/18/24 at 9:00 a.m., indicated the following: "... 36. The right to have the Community exercise reasonable care for the protection of your property from loss or theft." This citation relates to Complaint IN00441028.			
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance Based on interview and record review, the facility failed to ensure a medication self-administration assessment was completed prior to a resident self-administering medications for 1 of 3 residents reviewed for medication self-administration. (Resident C) Finding includes: Resident C's clinical record was reviewed on 9/16/24 at 2:04 p.m. The resident admitted to the facility on 7/30/24. Diagnoses included essential hypertension, unspecified depression, and	R 0216	1. The Director of Health and Wellness and/or designee will be re-educated by our Regional Director of Health and Wellness on the process for admission of a resident who is seeking to self-administer medication by 10.5.2024 2. The Health and Wellness Director and/or designee will complete the Self Administer Medication Assessment prior to move in and review with the	10/05/2024

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	09/18/2024

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
	anxiety. A provider's order indicated the resident may administer, store, and coordinate all medications without staff assistance. Current physician orders, dated 7/5/24, included the following: amlodipine (blood pressure) 10 milligrams (mg) - give 1 tablet by mouth daily, losartan (blood pressure) 100 mg - give 1 tablet by mouth daily, bisoprolol (blood pressure) 10 mg - give 1 tablet by mouth daily, and Effexor XR (depression) 150 mg - give 1 capsule by mouth daily. The clinical record lacked an assessment for self-administration of medications prior to the resident self-administering her medications. During an interview on 9/18/24 at 10:17 a.m., Resident C indicated she had been on the same medications prior to admission to the facility. She had been self-administering her own medications since she arrived at the facility on 7/30/24. The facility never administered her medications. During an interview on 9/18/24 at 10:50 p.m., the Administrator indicated the resident admitted to the facility on 7/30/24. During an interview on 9/18/24 at 10:56 a.m., the Director of Health and Wellness indicated the resident did not have a "Medication Self-Administration Safety Screen" completed prior to medication self-administration that began on 7/30/24. The safety screen was not completed until 8/5/24. During an interview on 9/18/24 at 10:56 a.m., the Administrator indicated she hoped the facility		administrator for compliance prior to any resident approved admission. 3. The Director of Health and Wellness and/or Designee shall complete a self-med assessments on each resident who is self-medicating and can be found in the resident's wellness file. 4. Audit measures going forward- Director of Health and Wellness and/or designee audit 2 charts/ month for 6 months and report results to ED. If there are no discrepancies observed within that 6-month period, regular audits will discontinue, and sporadic audits going forward.	

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	09/18/2024

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
	followed Indiana state guidelines regarding obtaining the "Medication Self-Administration Safety Screening." A current facility policy, revised 7/12/23, titled "Medication Self-Administration," provided by the Director of Health and Wellness on 9/18/24 at 10:56 a.m., indicated the following: "Policy: All residents have the right to self-administer medications upon the order of their provider within certain parameters: ... 2. They can demonstrate to the Director Health & Wellness [DHW] or designee that they are capable of stating what condition the medication is treating, following the directions for the medications, and have been assessed using the recognized self-administration of medication assessment in the electronic health record. 3. ...The DHW along with the provider, will made the final determination of the resident's ability to self-administer medications...."			
R 0296 Bldg. 00	410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance Based on record review and interview, the facility failed to ensure narcotics were reconciled per facility policy for 3 of 3 medication carts reviewed for medication administration and storage. (Assisted Living 2, Assisted Living 1, and Memory Care carts) Findings include: 1. During a medication administration observation of the Memory Care cart, accompanied by QMA 4 on 9/17/24 at 12:15 p.m., the "Narcotics Sheet Count" was reviewed, and the following dates lacked shift to shift reconciliation of controlled medications:	R 0296	1. The community's med carts were audited by the Director of Health and wellness and designee on 09.22.2024 and 9.26.2024 to ensure the Narc Count and Narc count book were accurate. 2. The community's Director of Health and Wellness, or their designee, shall complete Narc count Audits weekly for 4 weeks, Bi-weekly for 4 weeks and Monthly for 4 Weeks. 3. Current med techs as well as nurses will be re-educated by the Director of Health and Wellness	10/10/2024

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	09/18/2024

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
	August 2024- 8/1/24: 11:00 p.m.- 7:00 a.m. 8/2/24: 3:00 p.m.- 11:00 p.m. and 11:00 p.m.- 7:00 a.m. 8/3/24: 3:00 p.m.- 11:00 p.m. 8/4/24: 7:00 p.m.- 11:00 p.m. 8/5/24: 3:00 p.m.- 11:00 p.m. and 11:00 p.m.- 7:00 a.m. 8/6/24: 7:00 p.m.- 11:00 p.m. and 11:00 p.m.- 7:00 a.m. 8/7/24: 7:00 p.m.- 11:00 p.m. 8/8/24: 7:00 p.m.- 11:00 p.m. and 11:00 p.m.- 7:00 a.m. 8/9/24: 7:00 p.m.- 11:00 p.m. 8/10/24: 7:00 p.m.- 11:00 p.m. 8/11/24: 7:00 p.m.- 11:00 p.m. 8/12/24: 7:00 p.m.- 11:00 p.m. and 11:00 p.m.- 7:00 a.m. 8/13/24: 3:00 p.m.- 11:00 p.m. and 11:00 p.m.- 7:00 a.m. 8/14/24: 7:00 p.m.- 11:00 p.m. 8/15/24: 7:00 p.m.- 11:00 p.m. and 11:00 p.m.- 7:00 a.m. 8/16/24: 7:00 p.m.- 11:00 p.m. 8/17/24: 7:00 p.m.- 11:00 p.m. 8/18/24: 7:00 p.m.- 11:00 p.m. 8/19/24: 7:00 p.m.- 11:00 p.m. and 11:00 p.m.- 7:00 a.m. 8/20/24: 7:00 p.m.- 11:00 p.m. and 11:00 p.m.- 7:00 a.m. 8/21/24: 7:00 p.m.- 11:00 p.m. and 11:00 p.m.- 7:00 a.m. 8/22/24: 7:00 a.m.- 3:00 p.m., 3:00 p.m.- 11:00 p.m., and 11:00 p.m.- 7:00 a.m. 8/24/24: 7:00 p.m.- 11:00 p.m. 8/25/24: 7:00 p.m.- 11:00 p.m. 8/26/24: 7:00 p.m.- 11:00 p.m. and 11:00 p.m.- 7:00 a.m. 8/27/24: 4:00 p.m.- 11:00 p.m. and 11:00 p.m.- 7:00		on our policy of Narcotics, Controlled Substances and preventing Drug Diversion by 10.10.2024	

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	09/18/2024

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
	a.m. 8/29/24: 7:00 p.m.- 11:00 p.m. and 11:00 p.m.- 7:00 a.m. 8/30/24: 7:00 p.m.- 11:00 p.m. and 11:00 p.m.- 7:00 a.m. 8/31/24: 7:00 p.m.- 11:00 p.m. September 2024- 9/1/24: 7:00 p.m.- 11:00 p.m. 9/2/24: 11:00 p.m.- 7:00 a.m. 9/3/24: 2:00 p.m.- 11:00 p.m. 9/4/24: 7:00 p.m.- 11:00 p.m. and 11:00 p.m.- 7:00 a.m. 9/5/24: 7:00 p.m.- 11:00 p.m. and 11:00 p.m.- 7:00 a.m. 9/6/24: 7:00 p.m.- 11:00 p.m. 9/8/24: 11:00 p.m.- 7:00 a.m. 9/9/24: 3:00 p.m.- 11:00 p.m. 9/10/24: 7:00 a.m.- 3:00 p.m. and 3:00 p.m.- 11:00 p.m. 9/11/24: 12:00 p.m.- 3:00 p.m. and 3:00 p.m.- 11:00 p.m. 9/12/24: 7:00 p.m.- 11:00 p.m. 9/14/24: 11:00 p.m.- 7:00 a.m. 9/15/24: 3:00 p.m.- 11:00 p.m. 9/16/24: 7:00 p.m.- 11:00 p.m. During an interview at the time of the observation, QMA 4 indicated the sign in/sign out sheet for narcotics should be completed after two staff members finish counting the narcotic medications and was done at the start and end of every shift. 2. During a medication storage observation, of the Assisted Living 2 cart, on 9/17/24 at 12:40 p.m., accompanied by QMA 3 the "Narcotics Sheet Count" was reviewed, and the following dates lacked shift to shift reconciliation of controlled medications:			

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	09/18/2024

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
	August 2024: 8/1/24: 11:10 p.m.- 7:00 a.m. 8/3/24: 3:00 p.m.- 11:00 p.m. 8/4/24: 3:00 p.m.- 11:00 p.m. 8/5/24: 11:00 p.m.- 7:00 a.m. 8/6/24: 11:15 p.m.- 7:00 a.m. 8/7/24: 3:00 p.m.- 11:00 p.m. 8/8/24: 11:15 p.m.- 7:00 a.m. 8/10/24: 3:00 p.m.- 11:00 p.m. 8/12/24: 11:00 p.m.- 7:00 a.m. 8/13/24: 3:00 p.m.- 11:00 p.m. and 11:00 p.m.- 7:00 a.m. 8/15/24: 11:15 p.m.- 7:00 a.m. 8/17/24: 3:00 p.m.- 11:00 p.m. 8/18/24: 3:00 p.m.- 11:00 p.m. and 11:00 p.m.- 7:00 a.m. 8/19/24: 11:30 p.m.- 7:00 a.m. 8/20/24: 11:15 p.m.- 7:00 a.m. 8/21/24: 3:00 p.m.- 11:00 p.m. and 11:00 p.m.- 7:00 a.m. 8/22/24: 11:20 p.m.- 7:00 a.m. 8/25/24: 7:00 a.m. - 3:00 p.m. and 11:15 a.m. - 7:00 a.m. 8/26/24: 3:00 p.m.- 11:00 p.m. and 11:00 p.m.- 7:00 a.m. 8/27/24: 11:45 p.m.- 7:00 a.m. 8/29/24: 11:30 p.m.- 7:00 a.m. 8/31/24: 3:00 p.m.- 11:00 p.m. September 2024- 9/1/24: 3:00 p.m.- 11:00 p.m. 9/2/24: 11:15 p.m.- 7:00 a.m. 9/4/24: 10:30 p.m. - 7:00 a.m. 9/5/24: 11:00 p.m. - 7:00 a.m. 9/6/24: 3:00 p.m. - 11:00 p.m. 9/8/24: 7:00 a.m. - 3:00 p.m. and 3:00 p.m. - 11:00 p.m.			

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	09/18/2024

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
	9/9/24: 3:00 p.m. - 11:00 p.m. 9/10/24: 7:00 a.m. - 3:00 p.m. 9/11/24: 7:00 a.m. - 3:00 p.m. 9/12/24: 11:00 p.m. - 7:00 a.m. 9/14/24: 3:00 p.m. - 11:00 p.m. and 11:00 p.m. - 7:00 a.m. 9/15/24: 3:00 p.m. - 11:00 p.m. 9/16/24: 11:00 p.m. - 7:00 a.m. During an interview, at the time of the observation, QMA 3 indicated the sign in/sign out sheet was to be completed at every shift change. 3. During a medication storage observation of the Assisted Living 1 cart, on 9/17/24 at 12:41 p.m. and accompanied by LPN 5, the "Narcotics Sheet Count" was reviewed, and the following dates lacked shift to shift reconciliation of controlled medications: August 2024- 8/1/24: 7:00 p.m. - 11:00 p.m. and 11:00 p.m. - 7:00 a.m. 8/2/24: 7:00 p.m. - 11:00 p.m. 8/4/24: 11:00 p.m. - 7:00 a.m. 8/5/24: 3:00 p.m. - 11:00 p.m. and 11:00 p.m. - 7:00 a.m. 8/8/24: 11:00 p.m. - 7:00 a.m. 8/10/24: 7:00 a.m. - 3:00 p.m. and 3:00 p.m. - 11:00 p.m. 8/11/24: 7:00 a.m. - 3:00 p.m. and 3:00 p.m. - 11:00 p.m. 8/12/24: 3:00 p.m. - 11:00 p.m. and 3:00 p.m. - 11:00 p.m. 8/13/24: 7:00 a.m. - 3:00 p.m., 3:00 p.m. - 11:00 p.m., and 11:00 p.m. - 7:00 a.m. 8/14/24: 8:00 p.m. - 11:00 p.m. 8/15/24: 11:00 p.m. - 7:00 a.m.			

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	09/18/2024

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
	8/16/24: 7:00 p.m. - 11:00 p.m. 8/18/24: 3:00 p.m. - 11:00 p.m. 8/19/24: 7:00 p.m. - 11:00 p.m. and 11:00 p.m. - 7:00 a.m. 8/20/24: 7:00 a.m. - 3:00 p.m., 3:00 p.m. - 11:00 p.m., and 11:00 p.m. - 7:00 a.m. 8/21/24: 7:00 a.m. - 3:00 p.m., 3:00 p.m. - 11:00 p.m., and 11:00 p.m. - 7:00 a.m. 8/22/24: 7:00 a.m. - 3:00 p.m., 3:00 p.m. - 11:00 p.m., and 11:00 p.m. - 7:00 a.m. 8/23/24: 7:00 a.m. - 3:00 p.m. and 3:00 p.m. - 11:00 p.m. 8/24/24: 7:00 a.m. - 3:00 p.m. and 3:00 p.m. - 11:00 p.m. 8/25/24: 7:00 a.m. - 3:00 p.m. and 3:00 p.m. - 11:00 p.m. 8/26/24: 7:00 a.m. - 3:00 p.m. and 3:00 p.m. - 11:00 p.m. 8/27/24: 7:00 a.m. - 3:00 p.m., 3:00 p.m. - 11:00 p.m., and 11:00 p.m. - 7:00 a.m. 8/28/24: 7:00 a.m. - 3:00 p.m. and 3:00 p.m. - 11:00 p.m. 8/29/24: 11:00 p.m. - 7:00 a.m. 8/30/24: 7:00 a.m. - 3:00 p.m. 8/31/24: 3:00 p.m. - 11:00 p.m. September 2024- 9/1/24: 3:00 p.m. - 11:00 p.m. 9/2/24: 7:00 p.m. - 11:00 p.m. and 11:00 p.m. - 7:00 a.m. 9/3/24: 3:00 p.m. - 11:00 p.m. 9/4/24: 11:00 p.m. - 7:00 a.m. 9/5/24: 11:00 p.m. - 7:00 a.m. 9/8/24: 3:00 p.m. - 7:00 p.m. 9/10/24: 3:00 p.m. - 11:00 p.m. 9/11/24: 3:00 p.m. - 11:00 p.m. 9/12/24: 3:00 p.m. - 11:00 p.m. 9/13/24: 7:00 a.m. - 3:00 p.m. and 8:00 p.m. - 11:00 p.m.			

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	09/18/2024

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
	9/14/24: 3:00 p.m. - 11:00 p.m. 9/15/24: 3:00 p.m. - 11:00 p.m. 9/16/24: 7:00 p.m. - 11:00 p.m. During an interview at the time of the observation, LPN 5 indicated the sign in/sign out sheet was completed at every shift change by the two staff members exchanging the medication cart keys. During an interview, on 9/17/24 at 12:44 p.m.. the Director of Health and Wellness indicated the expectation was for staff to complete the "Narcotic Count Sheet" with exchange of keys and with any change in responsibility of the medication cart. A current facility policy, revised 7/11/22, titled, "Narcotics, Controlled Substances, and Preventing Drug Diversion", provided by the Director of Health and Wellness, on 9/17/24 at 2:00 p.m., indicated the following: "... c. At the end of each shift, the staff member responsible for medication completing his/her shift, and the staff member responsible for medications starting his/her shift, count all narcotic medications and confirm that the amount on hand matches what it listed on the Narcotic Count Sheet for each medication. Both staff members will sign a Narcotic Reconciliation Sheet confirm the accurate count of narcotics on hand...."			
R 0299 Bldg. 00	410 IAC 16.2-5-6(c)(3) Pharmaceutical Services - Noncompliance Based on record review and interview, the facility failed to act upon pharmacy recommendations for 2 of 4 residents reviewed for pharmacy reviews. (Residents 93 and B) Findings include:	R 0299	1. Recommendations from August 2024, Pharmacy audit have been presented and/or emailed to providers for signature and consideration.	10/10/2024

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	09/18/2024

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
	1. Resident 93's clinical record was reviewed on 9/17/24 at 3:20 p.m. Diagnoses included Parkinson's Disease, urinary spasms, and vitamin D deficiency. A current physician order, dated 11/9/22, included Ditropan XL extended release 24 hour (overactive bladder) 10 milligrams (mg)- give 1 tablet by mouth two times a day. A current physician order, dated 7/5/23, included vitamin D (vitamin D deficiency) 125 micrograms/5000 units - give 1 capsule by mouth once daily. Review of a "Pharmacist's Recommendation to Prescriber," dated 6/13/24, indicated the resident had an order for vitamin D 5000 units daily since September 2022. A recent level was not located. The recommended daily dose was 2000 units once a normal level was reached. Obtain a level and decrease dose if appropriate. Review of a "Pharmacist's Recommendation to Prescriber," dated 8/8/24, indicated the resident had an order for Ditropan XL 24 hour 10 mg twice daily for overactive bladder. This medication was not recommended for use in patients greater than 65 years of age due to risk of increased sedation and anticholinergic effects. Recommend changing to Gemtesa 75 mg daily or Myrbetriq 25 mg daily. These medications did not have anticholinergic properties, making them ideal overactive bladder options for the elderly. If you wish to continue the resident on the current therapy, please consider every day dosing (since it is extended release). The resident's clinical record lacked indication of		2. Responses to provider recommendations received will be reviewed by the community's Health and Wellness Director and/or designee. Resident orders will be updated with provider recommendations as appropriate. 3. Pharmacy's recommendations will receive follow up from the Health and Wellness Director and/or designee within 7 business days of receipt of audit. The community's Health and Wellness Director/designee will continue to follow up with provider every 7 days or until confirmation of providers consideration has been received. 4. During monthly Quality Assurance Meetings, the Health and Wellness Director and/or designee will bring results of any non-compliance times 3 months, if 100% compliancy is achieved over this time audits will be discontinued. 5. The Director of Health and Wellness and/or designee will be re-educated on the policy for Pharmacy Review by the Executive Director by 10.4.2024. 6. The Director of Health and Wellness and or designee will re-educate the team of wellness nurses on the policy for pharmacy review by 10.10.2024.	

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	09/18/2024

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
	prescriber notification, prescriber responses to the above mentioned pharmacy recommendations, medication changes, or lab orders/values. 2. Resident B's clinical record was reviewed on 9/16/24 at 2:34 p.m. Diagnosis included congestive heart failure, atrial fibrillation, and polyneuropathy. A 7/25/24, "Care Evaluation and Service Plan" indicated Resident B had cognitive impairment. A pharmacy recommendation, dated 8/8/24, indicated Resident B had an order for Folic Acid (a supplement) three times daily since April. This was a high dose and may not be needed for maintenance. Consider obtaining a folic acid level and decreasing dose if appropriate. The recommendation follow up and provider signature (indicating agreement with recommended actions) date was 9/18/24. The clinical record lacked a folic acid level result. A pharmacy recommendation, dated 8/13/24, indicated Resident B had an order for pantoprazole (to treat heartburn) 40 milligrams (mg) twice daily. The only approved indication for twice daily was for short term treatment. Please consider reducing to once daily. If the order was continued at the current dose, please provide risk versus benefit evaluation to support use. The recommendation follow up and provider signature date was 9/18/24. The clinical record lacked a risk versus benefit evaluation to support the pantoprazole dose continuation. During an interview on 9/17/24 at 4:41 p.m., the Director of Health and Wellness indicated she			

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	09/18/2024

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
	received the "Pharmacist's Recommendations to the Provider" in her email every 60 days and forwarded them to the provider. A request was made for any provider responses or contraindication letters regarding Resident 93 and Resident B's pharmacy recommendations. During an interview on 9/17/24 at 5:30 p.m., the Director of Health and Wellness indicated she had not yet received provider responses back from a provider regarding the pharmacy recommendations. During an interview, on 9/18/24 at 11:30 a.m., the Administrator indicated there was not a policy related to provider reviews or community responses for pharmacy recommendations.			
R 0304 Bldg. 00	410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency Based on observation and interview, the facility failed to ensure medication carts were appropriately locked when authorized personnel were not present for 1 of 3 carts reviewed for medication administration. (Assisted Living 2 cart) Findings include: During an observation on 9/17/24 at 12:33 p.m., the Assisted Living (AL) 2 medication cart was found to be unlocked and unattended in front of the nurse station. A member of the housekeeping staff, who was working nearby, indicated they would attempt to locate the staff member responsible for the medication cart. During an observation and interview on 9/17/24 at 12:40 p.m., QMA 3 arrived at the AL 2 medication cart and indicated she was not aware she had	R 0304	1. Current QMA's and nurses will be re-educated on the Indiana State Regulation on Medication Management and Medication Management policy, which identifies how medications must be stored by the Director of Health and Wellness and/or designee completed by 10.10.2024. 2. The Health and Wellness Director and/or designee will audit medication carts on a weekly basis for the next 4 weeks and then biweekly for 4 weeks to ensure compliance of locked med carts when the authorized personnel are not present.	10/10/2024

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	09/18/2024

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
	forgotten to lock the medication cart before leaving the area. During an interview on 9/17/24 at 12:44 p.m., the Director of Health and Wellness indicated the expectation was for staff to lock the medication cart before leaving it unattended. A current facility policy, revised 7/11/22, titled, "Narcotics, Controlled Substances, and Preventing Drug Diversion", provided by the Director of Health and Wellness, on 9/17/24 at 2:00 p.m., indicated the following: "... All medications, including over-the-counter medications, are always kept in locked storage...."		3. The Health and Wellness Director and Executive Director will conduct random audits to ensure the Medication Carts/storage are secured when unattended.	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance Based on record review and interview, the facility failed to ensure a resident's desired code status was accurately reflected in the clinical record for 1 of 7 residents reviewed for emergency information. (Resident D) Finding includes: Resident D's clinical record was reviewed on 9/16/24 at 3:57 p.m. The resident's admission date was 1/5/24. Diagnoses included atherosclerotic heart disease, chronic kidney disease, and essential primary hypertension. The banner bar, found in the electronic health record below the resident's identification upon opening the resident's electronic record, included the following code status: cardiopulmonary resuscitation (CPR)- attempt resuscitation. A current physician order, dated 1/5/24, included	R 0356	1. The Director of Health and Wellness and/or designee have completed chart audits on current residents for code status verses resident current orders. Resident orders found to be non-compliant have been corrected by 10.3.2024. 2. Residents that are found to be non-compliant with not having a completed Indiana Post form will be corrected by 11.15.2024. 3. New resident move in's will be audited to ensure all emergency information is on record.	11/15/2024

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	09/18/2024

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
	CPR - attempt resuscitation. A code status sticker, below the resident's room number on the outside of the paper chart binder stored at the Nurse's Station indicated CPR. The current advanced directive, dated 6/17/24, in the resident's paper chart binder indicated the following was selected: "Do Not Attempt Resuscitation" (DNR). The advanced directive was signed by the resident and the physician. The signed service plan, dated 8/29/24, indicated the resident was oriented and independent with decisions about their care and environment. The resident made safe judgments and was able to recall and retain information (8/5/24). The service plan lacked information regarding the resident's code status wishes. During an interview on 9/17/24 at 2:59 p.m., LPN 5 indicated the resident's paper and electronic clinical record did not reflect the resident's current chosen code status. The electronic record had a "CPR-attempt resuscitation" order and banner bar, which she referred to during emergencies. She indicated this was inconsistent with the resident's current DNR advanced directive dated 6/17/24. The person who received the advanced directive should have ensured the entire clinical record reflected the code status changes when it was placed in the chart. During an interview on 9/17/24 at 4:38 p.m., the Health and Wellness Director indicated the resident's current code status was not updated and consistent throughout the paper and electronic clinical record. The resident's current advanced directive, dated 6/17/24, included a DNR code status while the paper and electronic record			

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	09/18/2024

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
	directed staff to attempt resuscitation. All areas of the resident's clinical record should have reflected the resident's choice on the advanced directive. A current facility policy, revised 6/20/22, titled "Advance Directives," provided by the Director of Health and Wellness on 9/16/24 at 9:45 a.m., indicated the following: "Policy Statement... Advance directives will be respected in accordance with state law and community policy... Policy Interpretation and Implementation... 18. Changes or revocations of an advance directive must be submitted in writing to the DHW [Director of Health and Wellness]... 19. The DHW or designee will notify the attending provider of advance directives so that appropriate orders can be documented in the resident's medical record and service plan...."			