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	07/19/2024

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 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		
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency 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	R 0217	1 Resident B moved out on 05-05-2024 home with hospice. The Health and Wellness Director and 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	09/10/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	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 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.		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. 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.	