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	01/31/2024

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 IN00427002 and IN00424212. Complaint IN00427002 - State deficiencies related to the allegations are cited at R0036. Complaint IN00424212 - No State Residential Findings related to the allegations were cited. Survey date: January 31, 2024 Facility number: 014080 Residential Census: 89 This State Residential Findings is cited in accordance with 410 IAC 16.2-5. Quality review completed February 1, 2024.	R 0000		
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to notify a cognitively impaired resident's family representative of a fall for 1 of 3 residents reviewed for falls.	R 0036	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	02/29/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Meredith McWade Peterson	Administrator of Record	02/09/2024

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.

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	Findings include: The clinical record for Resident B was reviewed on 1/31/24 at 11:01 a.m.. Diagnoses include hypertension, insomnia, depression, dementia with behavioral disturbance. The resident lived on the secured memory care unit. Review of a facility "Morse Fall" risk assessment dated 12/26/23 indicated the resident was at high risk for falls. Review of a facility incident report, dated 12/26/23, indicated the resident was found on the floor next to the bed. The facility notified the on-call manager, physician, and the hospice agency. The report lacked indication of family notification. Review of a progress noted, dated 12/26/23 at 12:15 a.m., indicated the resident was found on the bedroom floor next to her bed. She did not complain pain and was assisted up onto to her feet after her vitals were taken. During an interview on 1/31/24 at 3:00 p.m., the Administrator and DON indicated it is the expectation of the facility that resident falls would be reported to the resident representative. No policy related to the notification of responsible parties and/or family members was provided. This citation relates to Complaint IN00427002.		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. Resident B no longer lives at this community. Employee who had completed facility incident report is no longer employed by this community. Community standard related to incident reporting has been implemented, inclusive of detail regarding the notification of the resident's family member. The community's Director of Health and Wellness, or their designee, and the community's Memory Care Director, or their designee, shall complete training of current care Team Members to the community's standard no later than 2/29/2024. An inservice attendance log shall serve as evidence of completion, and shall be kept with the community's training files. Newly hired care Team Members shall be trained to fall protocols during initial orientation.	

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			Community's administrator reviewed community incident reports logged since 1/1/2024 on 2/5/2024 to verify documentation of community staff contacting family members of residents. Community's administrator, or their designee, shall continue to review community incident reports at least weekly through 2/29/2024 to verify that staff have contacted family members of residents, in the event of an incident. The community's Director of Health and Wellness, or their designee, and/or the community's Memory Care Director, or their designee shall complete incident report audits on a weekly basis through 3/31/2024, to verify staff have contacted family members of residents. Documentation of such audits shall be retained within the follow-up documentation for this POC. The community's Director of Health and Wellness, or their designee, and the community's administrator, or their designee, shall review community incident reports ongoing on a regular basis. Reviewed incident reports shall contain electronic signature of the community's Director of Health and Wellness, or their designee, and the community's administrator, or their designee.	