STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR GROVE SENIOR LIVING	5865 SUGAR LN, PLAINFIELD, , 46168

(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 a State Residential Licensure Survey. This visit included the Investigation of Intake 470758. Intake 470758 - State deficiencies related to the allegations are cited at R0144. Survey dates: October 5 and 6, 2026. Facility number: 012394 Residential Census: 113 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 14, 2026.	R 0000	**Statement of Non-Admission of Liability** Sugar Grove Assisted Living submits this Plan of Correction in response to the findings identified during the Indiana Department of Health survey. The submission of this Plan of Correction does not constitute an admission of fault, liability, or agreement with the findings or conclusions cited in the survey report. This Plan of Correction is submitted in the spirit of cooperation and demonstrates Sugar Grove Assisted Living's ongoing commitment to regulatory compliance, quality improvement, and the health, safety, and well-being of our residents. Sugar Grove Assisted Living reserves the right to dispute any findings through the appropriate administrative or legal	

			processes.	
R 0144	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(a) (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observations, interviews, and record review, the facility failed to ensure a resident's environment was maintained in a sanitary condition after fecal matter was observed on the rim of the toilet, a smear of feces was noted on the floor, and ants were observed for 1 of 1 resident rooms reviewed for environment (Resident B). Findings include: During a confidential interview, it was indicated that Resident B had an ongoing pest problem in her apartment that started shortly after she moved into the facility. The family had complained about the issue, and the facility had spot treated, but while that helped for a few days, the ants continued to return. It was indicated that the family visited the previous Sunday and saw that the resident's toilet was splattered	R 0144	R144 — Sanitation and Safety | 410 IAC 16.2-5-1.5(a) Correction completed: Resident B's apartment was cleaned and sanitized, including the bathroom, floor and bedside area. The ant concern was addressed and follow-up pest-control measures were completed. System-wide prevention: Resident apartments were reviewed for sanitation and pest concerns; identified issues were corrected. Housekeeping and nursing staff were educated on prompt reporting and response. Ongoing monitoring: The Housekeeping Supervisor will document daily sanitation checks for two weeks, followed by weekly checks for four weeks. The Executive Director will review findings and ensure prompt follow-up. Responsible: Housekeeping Supervisor / Executive Director Correction completion date: October 26, 2026	10/26/2026

	with fecal matter and there was a smear of feces on the floor outside of the bathroom. On 10/5/26 at 11:00 a.m., Resident B was observed. She was lying in her bed and woke easily to conversation. As she spoke, a line of small black ants was observed as they crawled up her bedside table and onto a Styrofoam cup. There were also crumbs on the floor near her bed with ants observed. There was a smeared brown stain on her floor and there was feces speckled in the toilet bowl and feces on the rim of the toilet. On 10/6/26 at 9:00 a.m., Resident B's room was observed a second time. Ants remained on the floor and on the same Styrofoam cup, the toilet was still speckled with feces and the brown smear remained on the floor. On 10/6/26 at 11:25 a.m., Resident B's room was observed with the Housekeeping Supervisor (HKS). She observed the ants, crumbs on the floor, brown smear on the floor, and the resident's toilet. The HKS indicated that nursing aides should let Housekeeping know when they notice pests, or other areas of concern in resident apartments that need to be spot cleaned. The HKS indicated she			

	was new to the position and setting up a new cleaning schedule and would ensure Resident B's room would receive additional spot checks. On 10/6/26 at 11:30 a.m., the Interim Administrator provided a copy of the facility's recent Pest Control log, and Resident B's room had previously been treated for ants on 7/6/26 and 8/4/26. On 10/6/26 at 11:45 a.m., the Interim Administrator indicated that the facility followed the Residential Regulations for maintaining a clean and sanitary environment for all residents. This Residential citation relates to Intake 470758.			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.	R 0273	R273 — Food and Nutritional Services | 410 IAC 16.2-5-5.1(f) Correction completed: The outdated prepared rice was discarded, and food storage areas were inspected for outdated or improperly labeled items; identified items were corrected or discarded. System-wide prevention: The facility’s food date-marking and disposal procedure was clarified in accordance with applicable food-safety requirements, and dietary staff were educated. Ongoing monitoring: The Dietary Director will document daily refrigerator checks for four weeks, followed by weekly	10/26/2026

	Based on observations and interviews, the facility failed to ensure expired leftover food was appropriately disposed of in a timely manner during 1 of 1 kitchen observations. Findings include: On 10/5/26 at 9:30 a.m., the facility kitchen was reviewed with the Dietary Director. While observing the walk-in refrigerator, a container of prepared rice was found sitting on a shelf. The label on the container indicated it was mushroom rice, and it was made on 9/24/26. The Dietary Director indicated that she wasn't sure if the facility leftover food policy said leftovers were good for 7 days or 10 days, but she guessed it probably should have been thrown out. The Dietary Director indicated they typically go through the refrigerator on Mondays and throw out any expired food. If the rice was made on 9/24/26, according to the Dietary Directors indicated practice of throwing out leftovers on Mondays, the rice should have been thrown away on 9/28/26. On 10/7/26 at 10:15 a.m. the Business Office Manager (BOM) indicated she could not find a policy that spoke to when leftover food should be discarded, but they would follow		checks for four weeks, with results reviewed by the Executive Director. Responsible: Dietary Director / Executive Director Correction completion date: October 26, 2026	

	state regulation.			
R 0301	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(5) (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observations, interviews, and record review, the facility failed to ensure all medications with a specific expiration timeframe after opening were appropriately labeled with an open date in 2 of 2 medication carts reviewed for appropriate medication labeling.	R 0301	R301 — Pharmaceutical Services | 410 IAC 16.2-5-6(c)(5) Correction completed: The cited medications were reviewed. Opened products with unverifiable opening or beyond-use dates were removed and replaced as appropriate following pharmacy guidance. System-wide prevention: Medication carts and storage areas were reviewed for labeling and expiration compliance. Medication administration staff were reeducated on dating medications when opened and following product-specific beyond-use instructions. Ongoing monitoring: The Director of Nursing or designee will document daily medication-cart audits for two weeks, then weekly audits for six weeks, and correct discrepancies immediately. Responsible: Director of Nursing / Executive Director Correction completion date: October 26, 2026	10/16/2026

	Findings include: On 10/6/26 at 9:00 a.m., the following was observed on the memory care medication cart one. - Resident 9 had an opened Novolog Insulin Flex pen (a fast-acting insulin), with no opened date on it. -Resident 9 had an opened Insulin Glargine Flex pen (a long-acting insulin,) with no opened date on it. - Resident 10 had an opened bottle of atropine eye drops (prescription medications that dilate the pupil, relax eye focusing muscles, and treat conditions like lazy eye), with no opened date on it. The current Atropine eye drop information leaflet indicated, "...Once you have opened the bottle it should be disposed of after four weeks ...." On 10/6/26 at 9:30 a.m., the following was observed on the memory care medication cart two. -Resident 12 had an opened bottle of ear wax removal drops, with no opened date on it. -Resident 11 had an opened bottle of Latanoprost eye drops (prescription prostaglandin			

	analog eye drop used to lower high fluid pressure inside the eye), with no opened date on it. -Resident 11 had an opened bottle of Dorzolamide Hydrochloride with Timolol Maleate 2%/0.5% eye drops (a prescription combination medication used to lower high eye pressure), with no opened date on it. On 10/6/26 at 12:30 p.m. a copy of an email exchange between the Director of Nursing (DON) and the facility pharmacist indicated, " ... Latanoprost eye drops remain effective for up to 6 weeks (42 days) after opening ... Dorzolamide eye drops should be used within 28 days after opening ...For multi-dose ear drops, including wax removal solutions, pharmaceutical guidance recommends discarding the product 28 days after opening ...". On 10/6/26 at 1:30 p.m. a copy of a current facility policy titled, "Labeling Medications", dated 1/22/24, was provided. That policy indicated, " ...7. Medications vials/bottles will be labeled with the date they were opened (seal broken) to ensure proper tracking for expiration purposes ...."			

R 0357	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(j)(1-3) (j) If a death occurs, information concerning the resident ' s death shall include the following: (1) Notification of the physician, family, responsible person, and legal representative. (2) The disposition of the body, personal possessions, and medications. (3) A complete and accurate notation of the resident ' s condition and most recent vital signs and symptoms preceding death. Based on record review and interview, the facility failed to ensure the necessary documentation concerning the death of a resident was included and maintained in the medical record for 1 of 2 closed records reviewed (Resident 6). Findings include: On 10/5/26 at 9:30 a.m., during the survey entrance conference, the Interim Administrator (ADM) provided a list of residents who had recently been discharged from the facility. Resident 6 was listed as having passed away. On 10/6/26 at 11:58 a.m., Resident 6's record was	R 0357	R357 — Clinical Records | 410 IAC 16.2-5-8.1(j)(1–3) Correction completed: Resident 6’s record was reviewed for existing supporting documentation. Any verifiable missing information was addressed through a properly dated addendum where appropriate; no information was backdated or invented. System-wide prevention: Applicable recent death records were reviewed for required notifications, disposition of the body, belongings and medications, and condition/vital-sign documentation. Nursing staff were reeducated on the Death of a Resident policy and a death-record checklist was implemented. Ongoing monitoring: The Director of Nursing will review each applicable death record within 24 hours or the next business day and audit all death records for 90 days. Results will be reviewed by the Executive Director. Responsible: Director of Nursing / Executive Director Correction completion date: October 26, 2026	10/26/2026

reviewed.

The record lacked documentation of; Notification of the physician, family, responsible person, and legal representative; The disposition of the body, personal possessions, and medications; A complete and accurate notation of the resident's condition and most recent vital signs and symptoms preceding death.

During an interview, on 10/6/26 at 12:35 p.m., the Director of Nursing (DON) indicated, there was no additional documentation or records she could locate related to Resident 6's death.

On 10/6/26 at 1:00 p.m., the DON provided a copy of current facility policy titled, "Death of a Resident," dated 8/1/25. The policy indicated, "Purpose: To establish the appropriate process for appropriate documentation is made in the clinical record and notification concerning the death of a resident. Procedure: I. When a resident is identified without signs of life the resident's advanced directives will be verified. 2. The physician will be notified of assessment findings. 3. The resident may be declared dead by a licensed physician or registered nurse with physician authorization in accordance with

	state law. 4. All information pertaining to a resident's death shall be recorded in the medical records. Details will include, but are not limited to, signs of death (ie. cool to touch, no pulse, not heart upon auscultation, rigor mortis, etc), date, time of death, the name and title of the individual pronouncing the resident dead. 5. The attending physician shall file a death certificate with the appropriate agency following applicable state law. 6. Notification will be made to report the death to the county coroner as indicated by state law. 7. Resident confined to Airborne, Contact, or Droplet Isolation Precautions expires, the Funeral Home Director must be notified of the confinement refer to Funeral Home Notification of Infectious Disease policy. 8. The Durable Power of Attorney/Responsible Party will be notified of the resident's deatl1. 9. Post-mortem care will be provided to the deceased resident prior to releasing the body for discharge. 10. Notification will be made to the mortician, as identified in the resident's medical record, for removal of the body from the facility. a. Information regarding final location of the deceased will be recorded in the medical record. b. The name of the person removing the deceased from the facility will be recorded			

	on the release for the body. The signed release will remain a part of the permanent closed medical record. 11. All personal effects of the resident shall be inventoried and recorded. The individual accepting the personal affects will sign the inventory record to acknowledge receipt of stated items ...."			

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 SIGNATUREHeather Angel	TITLEExecutive Director	(X6) DATE10/26/2026