STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR GROVE SENIOR LIVING COMMUNITY	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 the Investigation of Complaint IN00389430. Complaint IN00389430 - Unsubstantiated due to lack of evidence. Unrelated State Residential Finding cited. Survey date: November 22, 2022 Facility number: 012394 Residential Census: 109 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on December 1, 2022.	R 0000	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusion stated on the statement of deficiencies. This statement of correction is prepared and submitted solely because of requirements under state and federal laws. We cordially request a desk review regarding the alleged deficiency in lieu of any revisit.	
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using	R 0217	R 217 It is the intent of this facility to ensure that service plan(s)	12/31/2022

appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:

(1) The services offered to the individual resident shall be appropriate to the:

(A) scope;

(B) frequency;

(C) need; and

(D) preference;

of the resident.

(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.

(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.

(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.

(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.

are signed and dated by the residents\families.

Corrective Action:
Director of Nursing and Assistant Director of Nursing was in-serviced on 12/14/2022 on Functional Capacity Screen\Service Plans and the requirement for Resident\Family signature.

Identification of Other Residents: All Residents have the potential to be affected by the alleged deficient practice.
A 100% Audit of Residents Functional Capacity Screens will be completed.
This audit will be completed by 12/16/2022.

Measures: An Audit tool will be completed to ensure that all Residents that have received a Functional Capacity Screen will be signed by Resident\Family. In addition, any new Functional Capacity Screen that is completed will be signed by Resident\family. DON \ Designee will monitor audit tool 5 days a week for 1 month, 3 days a week for 1 month, then weekly for 1 month.

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 SIGNATURE	TITLE	(X6) DATE