STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	01/29/2026

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 Intake 466949. Intake 466949 - State deficiencies related to the allegations are cited at R0052. Survey dates: January 29, 2026 Facility number: 012394 Residential Census: 120 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on February 12, 2026.	R 0000		
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse;	R 0052		02/23/2026

(3) mental abuse;

(4) corporal punishment;

(5) neglect; and

(6) involuntary seclusion.

Based on observations, interview, and record review, the facility failed to adequately supervise and monitor a resident (Resident B) who resided on a secured memory care unit with a diagnosis of dementia, and was at risk for elopement, which resulted in neglect as Resident B was able to elope from the secured unit. This deficient practice had the potential to effect 37 of 37 residents who resided on the secured memory care unit and were at risk for elopement.

Findings include:

On 1/29/26 at 10:46 a.m., a record review was completed for Resident B. She had the following diagnoses which included, but were not limited to, dementia, gastro-esophageal reflux disease (GERD) (acid reflux), hypertension (HTN), and macular degeneration (a progressive eye disease damaging the macula to impair sharp, central vision while leaving peripheral vision intact).

An elopement assessment was

completed on 6/12/25 and indicated Resident B was at risk for elopement. The intervention was to move her to a secure unit. Goals included her safety would be maintained and she would not leave the community unattended.

A service plan, dated 6/12/25, indicated Resident B was at risk for elopement. Goal included she would not leave the community unattended, and her safety would be maintained. The service plan was not updated after the elopement occurred.

A progress note, dated 12/21/25 at 9:02 p.m., indicated Resident B was observed to be agitated and attempting to leave, moving between residents' rooms and not easily redirected. The primary care provider and Director of Nursing (DON) were notified.

A progress note, dated 12/27/25 at 1:00 p.m., indicated the Certified Nursing Aide (CNA) opened the door for Resident B and her family. Family indicated they found the resident out by the road with no coat on. Resident was carrying some items a decorative Santa doll and a couple boxes of chocolate. Resident B was assessed and warmed with a blanket and warm coffee. Resident B's arms were shaking at times. No visible injuries or

complaints of pain were noted. Resident reassured.

An elopement book was provided on 1/29/26, and Resident B's picture and pertinent information were included in the book.

An elopement investigation was completed on 12/28/25. The investigation indicated Resident B had severe cognitive impairment. It indicated Resident B exited the community alone. She was wearing long pants and long-sleeved shirt. The weather was 52 degrees outside, and she was found walking on the sidewalk by her family. She was away from the community for six and a half minutes.

On 1/29/26 the DON was interviewed. She indicated Resident B was hiding in a "cubby hole" just before the entrance doors. The dietary staff exited the unit and did not ensure the door was completely closed. This allowed the resident to get out of the doors and then she immediately exited through another door just outside the secure doors. She made it off campus and onto the main road but remained on the sidewalk. Her family was coming to see her and noticed her walking on the sidewalk and brought her back to the facility. The weather was 52 degrees,

and resident was out of sight for six and a half minutes. She conducted an investigation and educated staff on elopement procedures. Maintenance checked the doors and continued to check the doors to ensure proper functioning on a weekly basis.

A policy titled, "Elopements," last reviewed on 5/2023, was provided by the Administrator on 1/29/26 at 11:31 a.m. It indicated, " ...For the purpose of this policy, "missing residents" shall be defined to mean a resident who has left the facility grounds without signing him/herself out of the facility ...." The policy also included ... "Resident who are at risk for elopement shall be provided at least one of the following safety precautions by the facility: door alarms on facility exits; and/or a personal safety device that alerts staff when the resident has left the building without supervision or staff supervision ...."

This citation relates to Intake 466949.

Based on observations, interview, and record review, the facility failed to adequately supervise and monitor a resident (Resident B) who resided on a secured memory care unit with a diagnosis of dementia, and was at risk for

	elopement, which resulted in neglect as Resident B was able to elope from the secured unit. This deficient practice had the potential to effect 37 of 37 residents who resided on the secured memory care unit and were at risk for elopement. Findings include: On 1/29/26 at 10:46 a.m., a record review was completed for Resident B. She had the following diagnoses which included, but were not limited to, dementia, gastro-esophageal reflux disease (GERD) (acid reflux), hypertension (HTN), and macular degeneration (a progressive eye disease damaging the macula to impair sharp, central vision while leaving peripheral vision intact). An elopement assessment was completed on 6/12/25 and indicated Resident B was at risk for elopement. The intervention was to move her to a secure unit. Goals included her safety would be maintained and she would not leave the community unattended.			

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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