STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER PLACE	2216 N RILEY HWY, SHELBYVILLE, , 46176

(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 467959. Intake 467959 - State Residential findings related to the allegations are cited at R0045 and R0247. Survey dates: February 19 and 20, 2026 Facility number: 004444 Residential Census: 28 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on February 26, 2026.	R 0000		
R 0045	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(r)(6-9) (6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the	R 0045		03/03/2026

	department, do the following: (A) Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident ' s clinical record and transmit a copy to the following: (i) The resident. (ii) A family member of the resident if known. (iii) The resident ' s legal representative if known. (iv) The local long term care ombudsman program (for involuntary relocations or discharges only). (v) The person or agency responsible for the resident ' s placement, maintenance, and care in the facility. (vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions. (vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F). (B) Record the reasons in the resident ' s clinical record. (C) Include in the notice the items described in subdivision (9).			

	(7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged. (8) Notice may be made as soon as practicable before transfer or discharge when: (A) the safety of individuals in the facility would be endangered; (B) the health of individuals in the facility would be endangered; (C) the resident ' s health improves sufficiently to allow a more immediate transfer or discharge; (D) an immediate transfer or discharge is required by the resident ' s urgent medical needs; or (E) a resident has not resided in the facility for thirty (30) days. (9) For health facilities, the written notice specified in subdivision (7) must include the following: (A) The reason for transfer or discharge. (B) The effective date of transfer or discharge. (C) The location to which the resident is transferred or discharged. (D) A statement in not smaller than 12-point bold type that reads, " You			

	have the right to appeal the health facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number listed below. " . (E) The name of the director and the address, telephone number, and hours of operation of the division. (F) A hearing request form prescribed by the department. (G) The name, address, and telephone number of the state and local long term care ombudsman. (H) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission. Based on interview and record review, the facility failed to			

	ensure a resident had the required paperwork provided prior to transfer; the receiving local hospital emergency room received documentation of the resident's demographic information and reason for transfer to the emergency room; and the facility's Executive Director and/or designee was notified of the resident being transferred to the local emergency room prior to the transfer for a non-emergent situation for 1 of 3 residents reviewed for resident's rights. (Resident B) Findings include: In a telephone interview with the local hospital's emergency room representative on 2-19-26 at 10:58 a.m., she indicated when Resident B was admitted to emergency room (ER) in the early hours of 2-11-26, a emergency medical services (EMS) staff member shared he had spoken with an unnamed CNA at the facility and the CNA was unable to provide the face sheet information. The residents face sheet information typically included, but were not limited to, the resident's name, date of birth, address, diagnoses, medications, allergies and contact information. The CNA informed the EMS staff that the face sheets were kept in the medication room and only the			

	nurses had access to the medication room, "so he was sent here with no information, no paperwork." The EMS staff informed the ER staff that the facility CNA shared information related to the nurse scheduled for that shift had called off and that meant no one had access to the med room at that time. "Our concern was the obvious one of not having any information on the patient." In an interview with the Executive Director (ED) and the Wellness Director (WD) on 2-20-26 at 11:15 a.m., the ED indicated he was not notified of Resident B being sent to the local ER until after he arrived for work on 2-11-26, sometime after 8:30 a.m. The ED indicated during that time period in early February, 2026, the facility was experiencing staffing issues. He clarified on the night shift for 2-10-26 at 10:00 p.m., through 2-11-26 at 6:00 a.m., there was not a licensed nurse or Qualified Medication Aide (QMA) scheduled from 11:00 p.m. until 6:00 a.m. That particular shift had a new CNA and a CNA from a another facility scheduled to work. The ED indicated the phone numbers for he and the WD were displayed near where the "Resident Emergency Binder," was maintained for staff use.			

	The binder was maintained with information for each resident, with their facesheets, current medication orders and the State regulatory paperwork that was to be filled out by staff and sent with any transfers to the hospital or ER. Resident B's information was observed to be a part of the facility's emergency binder, as well as copies of the State regulatory paperwork was present in the binder. The ED demonstrated the location of these materials and the information was observed to be located in the non-public area of the receptionist's desk area near the facility entrance and near the ED's and WD's offices. In an interview with the WD and the ED on 2-20-26 at 11:15 a.m., the WD indicated she had worked on 2-10-26 from approximately 8:00 a.m. until 11:00 p.m. She was aware Resident B had complained of stomach discomfort prior to her leaving at 11:00 p.m., but it was not of a nature that she considered emergent and the WD did not document this information in the clinical record. She did not learn of Resident B being sent out to the hospital until she returned to work on the morning of 2-11-26. The WD clarified by the time she arrived to work, Resident B was already			

	back to the facility from his transfer to the ER. Her expectation for any residents that were requiring a transfer to the local ER would be that the staff on duty would notify her prior to sending the resident out of the facility for care. When the WD spoke with CNA 3 in regards to Resident B being sent out to the hospital the morning of 2-11-26, CNA 3 shared with her that due to being a new employee at the facility she was unsure what she needed to do as Resident B was requesting to be sent to the local ER. She added CNA 3 told her the other CNA on duty was on break and she decided to go ahead and do as Resident B requested. The CNA 3 advised the WD she was unsure where to locate any of the facesheets or other paperwork that typically accompanies residents when they are transferred to the hospital or ER. The WD indicated that due to her living close-by, she had the ability to return to the facility to provide any needed information or medications if contacted by the facility staff, in addition to being readily available for any questions or concerns by phone. The WD indicated after the incident, she educated CNA 3 on notification of the ED and/or WD before a resident transfers			

	out of the facility, as the staff member may be unaware of where to locate information or the staff member may not be familiar with other issues that can affect why or where a resident may be transferred to. The WD did not document the staff education in CNA 3's employee record. The clinical record of Resident B was reviewed on 2-19-26 at 10:29. The resident's diagnoses included, but were not limited to, benign prostatic hyperplasia (enlarged prostate) and elevated cholesterol levels. The resident was alert and oriented, independently ambulatory, and used a rolling walker for mobility. A review of Resident B's nursing care notes, on 2-10-26, indicated no entries were documented related to the resident's stomach discomfort. The first entry on 2-11-26 was at 8:00 a.m., which indicated the resident complained of stomach pain and requested to go to the local ER for evaluation and treatment. It did not indicate the time of the complaint or request; it did indicate he was "stable at the time of transport." The next entry, dated 2-11-26 at 8:15 a.m., indicated Resident B returned to the facility, with no time of return indicated. The note indicated the ER labs were			

	"normal levels...CT imagining shows no obvious acute process." The resident attested to issues with gastrointestinal gassiness. The third and final notation for 2-11-26 was timed for 10:00 a.m., which indicated Resident B voiced concerns to the ED and WD related to staffing during the previous night. In an interview with Resident B on 2-19-26 at 10:45 a.m., he recalled going out to the local ER about one week prior, related to stomach pain/discomfort. At the hospital testing was conducted with all results "normal," with determination of "gas pains." He did not address any concerns for care or staffing. On 2-20-26 at 11:10 a.m., the WD provided a copy of the facility's "Hospital/Facility Transfer Form." This document indicated Resident B was being sent to the local hospital on 2-11-25 at 12:01 a.m., due to "abdominal pain." It indicated, under the portion of the document labeled, "List of Diagnoses," the resident was alert and oriented and "Verbal consent to ER." This document was signed by the WD and dated 2-19-26, eight (8) days after Resident B was sent to the ER. In an interview with the WD on 2-20-26 at 11:12 a.m., she			

	indicated the state required transfer paperwork was not sent with Resident B at the time of the transfer, but was sent to the hospital the following day by fax. The accompanying state regulatory paperwork, "Notice of Transfer or Discharge," (state form 49669), dated 2-11-26, indicated Resident B's "Reason for Transfer or Discharge," was listed as, "The transfer or discharge is necessary to meet the resident's welfare and the resident's needs cannot be met in the facility." The WD was unable to explain the discrepancy between the document's date on the form and when the documents were indicated to have been faxed to the hospital. On 2-19-26 at 12:15 p.m., the ED provided a copy of a policy, dated 6-10-24, entitled, "Discharge Related to Non-Emergency Status." This policy indicated, "Discharge out of the Community is carried out in a manner that will limit transfer trauma for the resident and enhance communication...When a transfer or discharge of a resident is proposed, whether interfacility or interfacility [sic] provision for continuity of care shall be provided by the facility. Health facilities must permit each resident to remain in the facility and not transfer or			

	discharge the resident from the facility unless: The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility...When the facility proposes to transfer or discharge a resident under any of the circumstances specified in regulations, the resident's clinical records must be documented...Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following: Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident's clinical record and transmit a copy to the following: The resident...The person or agency responsible for the resident's placement, maintenance, and care in the facility...Record the reasons in the resident's clinical record...Notice may be made as soon as practicable before transfer or discharge..." This citation relates to Intake 467959. 2.5-1.2(r)(6)(A)(v) 2.5-1.2(r)(6)(B)			

	2.5-1.2(r)(6)(A)(v) 2.5-1.2(r)(9)(A) 2.5-1.2(r)(9)(B) 2.5-1.2(r)(9)(C)			
R 0247	Health Services - Deficiency 410 IAC 16.2-5-4(e)(7) (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on interview and record review, the facility failed to ensure residents received their medications timely during the night shift hours of 6:00 p.m. to 6:00 a.m. as ordered by the prescriber for 3 of 3 residents reviewed for heath services. (Residents E, F, and G) Findings include: In an interview with the Executive Director (ED) and the Wellness Director (WD) on 2-20-26 at 11:15 a.m., the WD indicated she had worked on 2-10-26 from approximately 8:00 a.m. until 11:00 p.m. She had ensured all medications that were scheduled during her time in the facility had been	R 0247		03/03/2026

administered and there were no additional medications due until the next shift arrived at 6:00 a.m. There were a few 5:00 a.m. medications that were scheduled, but those medications could be handled by the on-coming shift, due to the facility honored "the one hour before and one hour after the scheduled times as okay." Due to her living close-by, she had the ability to return to the facility to provide any needed medications if contacted by the facility staff, in addition to being readily available for any questions or concerns by phone.

The clinical record of Resident E was reviewed on 2-20-26 at 12:35 p.m. Her diagnoses included, but were not limited to, hypothyroidism (underactive thyroid). A review of her medications indicated she was ordered to receive levothyroxine 150 micrograms (mcg) once daily by mouth at 5:00 a.m., for hypothyroidism. A review of the medication administration record (MAR) for February, 2026, indicated on 2-11-26, the medication was administered at 7:11 a.m. The clinical record did not indicate the medication had been given over two hours late, any notifications had been made to the WD or ED, the physician or the resident's responsible party or if any

monitoring post-event had been conducted.

The clinical record of Resident F was reviewed on 2-20-26 at 12:44 p.m. Her diagnoses included, but were not limited to, hypothyroidism. A review of her medications indicated she was ordered to receive levothyroxine 112 micrograms (mcg) once daily by mouth at 5:00 a.m., for hypothyroidism. A review of the medication administration record (MAR) for February, 2026, indicated on 2-11-26, the medication was administered at 7:28 a.m. The clinical record did not indicate the medication had been given over two hours late, any notifications had been made to the WD or ED, the physician or the resident's responsible party or if any monitoring post-event had been conducted.

The clinical record of Resident G was reviewed on 2-20-26 at 12:55 p.m. Her diagnoses included, but were not limited to, hypothyroidism. A review of her medications indicated she was ordered to receive levothyroxine 75 micrograms (mcg) once daily by mouth at 5:00 a.m., for hypothyroidism. A review of the medication administration record (MAR) for February, 2026, indicated on 2-11-26, the medication was administered at 8:40 a.m. The clinical record did

not indicate the medication had been given over three hours late, any notifications had been made to the WD or ED, the physician or the resident's responsible party or if any monitoring post-event had been conducted.

On 2-20-26 at 12:57 p.m., the ED provided a copy of a policy dated 6-10-24, and entitled, "Medication Services." This policy indicated, "The Community provides medication ordering and medication assistance/administration services...Medications may be given up to one (1) hour before and up to one (1) hour after the prescribed time to accommodate the resident's schedule unless otherwise indicated by the resident's physician..."

On 2-20-26 at 12:46 p.m., the ED provided a copy of a policy dated 6-10-24, and entitled, "Medication Errors." This policy indicated, "Medications are handled in a manner that minimizes the risk of medication errors. A medication error is defined as...Wrong time...The individual identifying the medication error immediately reports the error to the Director of Health and Wellness. If the Director of Health and Wellness is not available, the report will be made to the nurse on-duty or

	Executive Director. The prescribing physician is immediately notified of the medication error...Document and follow instructions provided by the physician. Monitor the resident for signs and symptoms of a serious adverse reaction...Record resident's vital signs and report to the physician. If an adverse reaction is noted, immediately call 911. Enter a narrative note on the resident's status during every shift for forty-eight (48) hours after a medication error has occurred. Notify the resident's responsible party of the medication error..." This citation relates to Intake 467959. 2.5-4(e)(7)			

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