STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS AT REAGAN PARK	1176 KINGWOOD DRIVE, AVON, , 46123

(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 Intakes 466332, and 466670. Intake 466332 - State deficiencies related to the allegations are cited at R117, R118, R246, and R296. Intake 466670 - State deficiencies related to the allegations are cited at R052. Survey date: December 16, and 18, 2025 Facility number: 013264 Residential Census: 73 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on December 31, 2025.	R 0000		
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6)	R 0052		01/06/2026

(v) Residents have the right to be free from:

(1) sexual abuse;

(2) physical abuse;

(3) mental abuse;

(4) corporal punishment;

(5) neglect; and

(6) involuntary seclusion.

A. Based on interview and record review, the facility failed to prevent neglect of a resident when staff delayed Cardio-Pulmonary Resuscitation (CPR) according to the resident's code status preference when a change of condition occurred, and failed to follow the CPR procedure for unresponsive residents for 1 of 3 residents reviewed for quality of care and treatment (Resident B) resulting in harm when the resident was revived with an anoxic brain injury.

B. Based on interview and record review, the facility failed to prevent neglect of a resident when staff failed to monitor, assess, and provide activities of daily living (ADL - bathing, dressing, eating, using the toilet, and moving [transferring/walking]) care for a resident diagnosed with COVID for at least 12 hours for 1 of 3 residents reviewed for quality of

	care and treatment (Resident B). Findings include: A. During an interview on 12/16/25 at 11:18 a.m., Resident B's representative indicated she was concerned with the amount of time it took staff to respond on 12/11/25 when the resident had been found unresponsive, subsequently resulting in her death later that day from an anoxic brain injury. The representative indicated Resident B had been admitted to the facility in May 2025 where she had been placed on the MC unit. The resident had been alert, could transfer and ambulate independently, could perform ADL's to include showering with oversight, she dressed herself in matching outfits, and put on her own makeup every morning. The resident had been scheduled to have a vein stent placement later in December 2025 related to a non-healing wound on the right heel that had recently caused her to have falls. On 12/11/25 at 8:30 a.m., the resident representative had received a call reporting Resident B's heart had stopped, staff had initiated CPR, and the resident had been transported to the ER. The family had gone to the hospital to be with the resident who subsequently died			

	around 2:50 p.m. Resident B's representative was upset regarding events captured by a camera inside the resident's room on 12/11/25. At approximately 7:15 a.m., the resident was woken up and taken to breakfast in a wheelchair (WC) per her normal routine. She was visibly alert with her head held up, although in great discomfort with movement as she had been for several days while recovering from COVID. At 8:20 a.m., Resident B was wheeled back into her room with her head slumping over and there was no sign of consciousness. Licensed Practical Nurse (LPN) 4 was overhead on the phone telling someone she did not think the resident had a pulse. At 8:23 a.m., the resident was transferred from the WC to bed, and she did not make a sound. For the next 7 minutes, there was great confusion as attendants were trying to determine the next steps. At 8:30 a.m., Resident B was moved from the bed to the floor where CPR was performed and around that time an ambulance was called. The resident was revived on the way to the hospital, but unfortunately sustained brain and bodily injury due to oxygen deprivation. Resident B subsequently died later in the afternoon. The resident representative indicated Resident B's room			

	was only 8 rooms from the desk, it was a short walk and should not have taken 8 minutes for the staff to verify code status and start CPR. The staff had repositioned the video camera, so that family members was unable to see any more footage to include the EMTs arriving at the resident's room. The ER staff had continued to work on Resident B after transport, but CT scans at the hospital indicated there was little to no brain activity left. Resident B's clinical record was reviewed on 12/16/25 at 10:30 a.m. Diagnoses on Resident B's profile include dementia, hypertension (high blood pressure), a history of a deep vein thrombosis (DVT - blood clot), history of taking blood thinners, peripheral vascular disease (PVD - blood vessels are narrowed or blocked), and critical limb ischemia (inadequate blood supply) of the lower right extremity. An Indiana Physician Orders for Scope of Treatment (POST) form for Resident B, dated 5/8/25, indicated if the resident had no pulse and was not breathing she wanted resuscitation/CPR. The treatment goal indicated the resident wanted full interventions including life support measures in the intensive care unit. In addition to			

	care described in comfort measures and limited additional interventions indicated the resident wanted the use of intubation, advanced airway interventions, and mechanical ventilation as needed. The resident was to be transferred to hospital and/or intensive care unit if indicated to meet medical needs. The physician order indicated the resident was a full code. A physician's order, dated 5/9/25, indicated Xarelto 10 milligrams (mg) 1 tablet daily for blood thinner. Progress notes, dated 12/11/25 at 7:01 a.m., Licensed Practical Nurse (LPN) 4 documented Resident B was assisted with morning care, gotten up from bed into a WC with transfer assistance of 2 staff, and placed in the unit common area awaiting breakfast. Progress notes, dated 12/11/25 at 9:05 a.m., LPN 4 documented Resident B had been assisted with ADL's this morning. She was up in a WC in the common area, and when the nurse went to attempt to feed the resident breakfast, the resident was found unresponsive. Oxygen saturations were 62% and her skin was cool to touch. CPR was initiated, 911 was called, and the Executive Director (ED)			

and Director of Nursing (DON) were notified. Resident B was left in care of paramedics upon their arrival. The daughter was notified and the resident was transferred to a local hospital.

A Progress Notes, dated 12/11/25 at 3:37 p.m., the DON documented a care manager from a local hospital called to notify the DON that Resident B had passed away at 2:42 p.m. with a diagnosis of cardiac arrest.

Observation of a sign posted on the outside of Resident B's locked door indicated, "Ring camera in use. This is how she communicates with family. Feel free to cover temporarily if needed to preserve dignity." The resident's room was 8 doors from the center of the memory care (MC) unit where the nurse's station was located.

Resident B's hard chart was observed on a shelf inside the nurse's station door. There was a green label on the outside spine of the chart with the resident's name, room number, and name of the physician. The green label indicated the resident's code status was full code.

Review of video camera footage from Resident B's room, dated 12/11/25, included:

a. At 5:49 a.m., an unidentified

	staff member was observed to enter the resident's room to provide incontinence care. The resident could be overheard moaning as she was moved during care. b. At 5:51 a.m. the unidentified staff member left the room. c. At 6:54 a.m. Certified Nursing Assistant (CNA) 6 was observed to enter the resident's room to provide morning care. LPN 4 and CNA 6 were observed transferring the resident into a manual WC. The resident could be overheard moaning with any movement of her body. d. At 7:12:39 a.m. the resident was wheeled from the room by CNA 6. The resident was alert and sitting up straight in the WC looking around. e. At 8:20:55 a.m. the resident was observed being wheeled back into her room in a WC, her head was resting on her chest, her extremities were lax, and she was unresponsive. When the WC was turned to be positioned by the bed, the resident's right foot rubbed against the bed, and the resident did not react. Staff left the room for approximately 1 minute, leaving the resident alone.			

f. At 8:22:52 a.m., LPN 4 was observed making a call on her cellphone at bedside.

g. At 8:23:49 a.m. The resident was transferred into the bed and covered with blankets to her chest. CNA 7 placed her hand on the resident's forehead above her eyes and stroked her hand down towards the resident's nose as if to close the resident's eyelids.

h. At 8:25:37 a.m. LPN 4 and LPN 5 were observed listening to the resident's chest with a stethoscope, they felt for a pulse at the carotid artery, and LPN 4 (the only CPR certified nurse on duty) left the room.

i. At 8:25:50 a.m. LPN 5 was observed feeling for pedal pulses and was heard asking CNA 6 and Home Health Aide (HHA) 7 if the resident was a full code status and referred to the sign taped at the back of the door.

j. At 8:26:07 a.m., full code status was verified by the blue sign on the back of the resident's door.

k. At 8:28:22 a.m. - 8:31:11 a.m. all staff members were observed to leave the room. The resident was left alone, and she was not seen moving or making noise from the bed.

l. At 8:31:46 a.m., LPN 4, LPN

	5, CNA 6, and HHA 7 were observed to reenter the room, and the resident was moved to the floor at bedside. m. At 8:31:50 a.m., LPN 4 initiated CPR on the resident. CNA 4 was observed to then turn the camera over which caused the recording to stop. Facility surveillance video camera footage of Resident B in the dining room and main hallway, dated 12/11/25, was reviewed with the ED and included: a. At 7:14 a.m., Resident B was brought to the dining room and placed at a table with two other residents. The resident was alert and looking around. b. At 7:18:26 a.m., the resident was moved to the lounge area beside the dining room. The resident was positioned facing the main hallway within 6 feet of dining tables where other residents were served drinks and breakfast. c. At 7:19:50 a.m., LPN 4 was observed to offer the resident a drink. d. From 7:24:36 a.m. to 7:50 a.m., the resident was observed to periodically move her hands around and off her lap. e. At 8:05:20 a.m., the resident was observed with a slight head			

movement. This was the last time the resident was observed moving her head.

f. At 8:18:53 a.m., LPN 4 was observed tapping the resident, saying something to her, and clipping a pulse oximeter to her finger.

g. At 8:20:14 a.m., Resident B was observed being pushed from the dining room by LPN 4, as CNA 6 and HHA 7 followed. The resident's chin was resting on her chest, and she was unresponsive.

h. At 8:29:30 a.m., CNA 6 and HHA 7 were observed walking down the hallway towards the dining room, their movements were unhurried.

i. At 8:31:06 a.m., LPN 4, LPN 5, CNA 6, and HHA 7 were observed hurrying down the hallway and entering Resident B's room.

j. At 8:32:10 a.m., two firemen arrived at the unit.

k. At 8:33:29 a.m., LPN 4 and CNA 6 left the resident's room.

l. At 8:34:25 a.m., Emergency Medical Services (EMS) arrived at the unit.

m. At 8:38 a.m., LPN 5 left the resident's room.

n. At 8:45 a.m., the DON arrived

	at the unit. o. At 8:50:33 a.m., Resident B was seen on a gurney leaving the facility with EMS. She was intubated, and a LUCUS device (Life Under Chest Compressions Assist System - a portable, battery-operated device that provides automated, consistent chest compressions for patients in cardiac arrest) was moving on her chest. A local Fire Department EMS report, dated 12/11/25, indicated they had been called to assist with an unconscious resident with signs and symptoms of cardiac arrest. Upon arrival the resident was found pulseless and apneic (stopped breathing) in her room. Facility staff had reported the patient had been found unresponsive approximately 8 -10 minutes prior to EMS arrival, and CPR was in progress by healthcare staff upon EMR arrival. Fire station staff had arrived just prior and had taken over CPR. First vitals were recorded at 8:38 a.m., indicated unable to obtain blood pressure (BP), pulse 61 beats per minute and respirations 13 per minute. The resident was in cardiac arrest, her eyes dilated, skin mottled, and no pulses were found in the lower extremities. EMS provided care to include oxygen, orotracheal intubation, intravenous (IV) therapy and			

	bolus of fluids, epinephrine (adrenaline) times 5 doses, CPR, and mechanical CPR. EMS arrived at a local hospital emergency department (ED) at 8:57 a.m. and transferred care to the hospital staff. A local hospital report, dated 12/11/25 at 9:13 a.m., indicated history obtained by EMS included, Resident B was reportedly last seen in her normal state of health at approximately 8:12 a.m. The resident was found unresponsive by facility staff at approximately 8:26 a.m., at which time CPR was started. EMS stated they arrived on scene at 8:32 a.m. and continued compressions and ultimately placed a LUCUS device. Code status on arrival was full code. Upon arrival 3 units of packed red blood cells (PRBC) was given, she was on a ventilator, and 3 vasopressors were started. The initial assessment plan included acute respiratory failure with hypoxia and hypercarbia, blood loss anemia, cardiac arrest, and gastrointestinal (GI) bleed. The neuro assessment indicated anoxic brain injury (where the brain is completely deprived of oxygen, often from events like cardiac arrest). Computed Tomography (CT scan - detailed cross-sectional [slices] of the body, showing bones, organs, soft tissue, and blood vessels)			

	of the abdomen/pelvis indicated occluded right common iliac and right external iliac artery stent. CT of the chest indicated no pulmonary artery embolism. CT scan of the head indicated no evidence of acute hemorrhage. X-ray of the chest indicated no acute cardiopulmonary findings. Multiple bilateral nondisplaced rib fractures and a nondisplaced sternal fracture. A local hospital addendum report, dated 12/12/25 at 8:49 a.m., indicated extended care Resident B had presented to the hospital after being found down at her facility, last known normal approximately 15 minutes prior to being found. She was pulseless, had CPR initiated. The patient received approximately 32 minutes of CPR prior to hospital arrival and an additional 22 minutes after arrival at the hospital, before return of ROSC (return of spontaneous circulation). Patient is status post prolonged resuscitative efforts with evidence of multisystem organ failure, encephalopathy consistent with anoxic injury, she received PRBC for concern of GI bleed although she did not appear to have ongoing brisk bleed, acute renal failure, and likely an ischemic bowel due to severe vascular disease and hypoperfusion state (inadequate blood flood to tissues leading to oxygen deprivation). Prognosis			

	for survival was very poor. During an interview on 12/16/25 at 12:34 p.m., the DON indicated she had received a call on 12/11/25 regarding Resident B. LPN 4 reported Resident B was not breathing and non-responsive, and she had initiated CPR and was calling 911. When the DON arrived at the facility, EMS staff were in the resident's room performing CPR and then shortly after transported her to a local hospital. Resident B's code status had been full code. The code status could have been found on a POST form in the hard chart, which was stored at the nurse's station. Labels on the outside of the chart were color coded, green for full code, and red for DNR (do not resuscitate.) During an interview on 12/16/25 at 1:36 p.m., HHA 7 indicated on 12/11/25, she was not assigned to take care of Resident B. CNA 6 had gotten the resident up and put her at the assistance table in the dining room. HHA 7 then made Resident B a small cup of coffee, but the resident did not interact or drink her coffee. LPN 4 or CNA 6 had then moved the resident to the lounge at the side of the dining room in front of the TV. At some point later, HHA 7 had heard LPN 4 repeatedly calling Resident B's			

	name and saw her taking her vital signs. LPN 4 took the resident to her room and instructed HHA 7 to get another nurse. When she returned, HHA 7 and CNA 6 helped put Resident B back into bed, the resident was still not responding at that time. HHA 7 then left to go watch the residents who were eating breakfast. During an interview on 12/16/25 at 1:47 p.m., LPN 4 indicated, on 12/11/25, she had been working on the MC unit which was her normal assignment. Resident B had been dealing with COVID and had not been feeling well. On 12/11/25 LPN 4 had assisted with getting the resident out of bed into a WC, and then around 7:30 a.m., the resident had been placed in front of the TV in the lounge by the dining room as she awaited breakfast. The resident had a cup of liquid next to her, but she was not drinking it. LPN 4 passed some medications and then when she went to get the resident, she did not respond to her greeting, and her hand was cold to the touch. Oxygen saturations were reading 66%, the resident was still not responding to their voices or touch, so staff were called to help take the resident back to her room. LPN 4 went to the nurse's office to check the chart for code status, summoned LPN 5 from the other side of the			

	facility, placed Resident B on the floor and started CPR. LPN 4 indicated she had called the ED from her cellphone as she went down the hallway and called 911 from the office phone while LPN 5 stayed in the room with the resident. LPN 4 initiated CPR after she returned to the resident's room, and she had called the resident's daughter while EMS was working on the resident. During an interview on 12/16/25 at 2:00 p.m., CNA 6 indicated, on 12/11/25, she had gotten Resident B up for breakfast with the help of LPN 4, and the resident had been making grunting noises with movement. HHA 7 had made the resident some coffee as she liked it, but she did not drink it. Resident B had initially been sat at the feeding assistance table but then was moved in front of the TV at the nurse's request. CNA 6 then helped serve breakfast to the other residents. At one point she heard LPN 4 calling Resident B's name but there was no response. LPN 4 and CNA 6 took the resident back to her room and she was put into bed. The resident was unresponsive the whole time and did not make any noise. Resident B's husband could see the resident on the camera in the resident's room and started yelling at staff from the camera questioning what was			

	happening to his wife. CNA 6 indicated she had turned the camera upside down so the husband would not have to see the resident being cared for and having CPR. LPN 4 and CNA 6 placed the resident on the floor, LPN 5 was summoned to the room via walkie talkie, and LPN 4 was performing CPR when LPN 5 arrived at the room. CNA 6 indicated she had left the room to help monitor breakfast while LPN 4 did CPR. EMS arrived and took over CPR, and the resident was taken to the hospital. During an interview on 12/16/25 at 2:16 p.m., LPN 5 indicated, on 12/11/25 around 8:00 a.m., she had been called via walkie talkie to go to the MC unit. She was not sure of the time, but she had been passing medications. When she arrived at the unit, Resident B had been sitting in a WC at bedside in her room, and she was unresponsive. LPN 5 was told the resident had been found unresponsive and the nurse had already called 911. Staff members then put the resident to bed where the nurses checked for pulses without success. There was a blue sign on the back of the resident's door that indicated full code, but LPN 4 also went to the nurse's station to check for code status. Code status could be identified by the green label on the hard			

	chart or by a POST form in the chart. After LPN 4 returned to the room, Resident B was placed on the floor and LPN 4 initiated CPR. LPN 5 left soon after and returned to her unit, she had not been present when the resident left via ambulance for the hospital. LPN 5 indicated she was not aware there had been a camera in the room. During an interview on 12/18/25 at 11:46 a.m., the ED indicated a resident's code status could be identified by visualizing the color of the resident nametag on the outside of the chart. The tag would be green for full code or perform CPR, or red for No Code or DNR. The ED indicated, to her knowledge, there never was colored paper on the back of the residents' doors that would signify a code status. During an interview on 12/18/25 at 12:44 p.m., LPN 4 indicated a resident's code status could be found in the electronic medical record (EMR) on the face sheet, in the physician's orders, by the color-coded name label on the spine of the hand chart inside the nurse's station, or on an advanced directive form or POST form in the hard chart. When a resident was found unresponsive, CPR should be started as soon as possible after the code status was confirmed, maybe a couple of minutes.			

	LPN 4 indicated, she thought everyone working in the MC unit was CPR certified. During an interview on 12/18/25 at 1:25 p.m., the ED indicated, on 12/11/25, Resident B had been taken from the lounge beside the dining room back to her room at 8:20 a.m., and CPR was not started until 8:31 a.m. The expectation would be for CPR to be started immediately. The ED indicated that not every staff member was expected to have CPR certification, although sessions were offered for all nursing staff. The ED indicated she did not know in an emergency situation how the staff working in the facility would know who was certified in CPR. The staff member should call the lead nurse on duty for guidance. The ED indicated the facility had no policy for CPR guidance. The facility followed the State regulation for Licensed Residential of "A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times." On 12/18/25 at 11:46 a.m., the ED provided a Code Status policy, dated 6/14, and indicated the policy was the one currently being used by the facility. The policy indicated, "It is the policy of this community that all			

	residents will have upon admission a code status established. Procedure. 1. At the time of admission, the Executive Director/Leasing Director will sign admission paperwork with the resident or resident's representative. 2. The Resident Clinical Director will give to the resident or resident representative the Advanced Directives Acknowledgement Form. 3. If the resident chooses to formulate and issue the advanced directive for Do Not Resuscitate, the Resident Clinical Director will complete the discussion for Do Not Resuscitate. 4. The Do Not Resuscitate form is completed by the resident and/or representative and a copy given to the resident. 5. The Do Not Resuscitate Form is then given to the Resident Clinical Director to fax to the physician for signature. 6. When the form is signed by both the resident and/or representative and the physician, it is then placed in the resident's chart in the Advanced Directive section." B. During an interview on 12/16/25 at 11:18 a.m., Resident B's representative indicated on 12/4/25, Resident B had tested positive for COVID and placed in isolation where the family was not allowed to visit. On 12/8/25, a home health nurse had visited to provide wound treatments on the			

	resident's right foot and left lower leg, and during her visit had found the resident's oxygen level around 88% and the resident becoming dehydrated. The resident was not given an oxygen order at that time, but staff hand fed her in her room and were pushing fluids. The video camera footage showed the staff beginning to put the resident to that night around 6:00 p.m., and the staff did not check on the resident for 12 hours when someone entered around 6:00 a.m. on 12/9/25 to change her brief. Another staff member entered the room on 12/9/25 around 8:00 a.m. to offer the resident breakfast, meaning the resident had been approximately 14 hours without being offered food or drinks when they knew she was becoming dehydrated. During the night around 2:00 a.m., the resident representative had attempted twice to call staff to check on the resident, but there was no answer to her phone calls. On 12/9/25, Resident B's representative had called the ED to report her concerns about the night staff not checking the resident all night, and the ED had acknowledged effort from the prior day to hydrate and feed the resident had been negated. On 12/9/25 staff had taken the resident to the dining room and attempted to feed her breakfast, but she had been in pain, and they had gotten her			

	up in a chair for a bit, but she just wanted to sleep all day. On 12/10/25 Resident B was gotten up and taken out of her room to the main area through dinner without being brought back to her room to rest or change her brief. At that point the family thought the resident must have been doing better because she had been left up all day. Resident B's clinical record was reviewed on 12/16/25 at 10:30 a.m. Diagnoses on Resident B's profile include dementia, hypertension (high blood pressure), a history of a deep vein thrombosis (DVT - blood clot), history of taking blood thinners, peripheral vascular disease (PVD - blood vessels are narrowed or blocked), and critical limb ischemia (inadequate blood supply) of the lower right extremity. Progress notes, dated 12/4/25 at 10:00 a.m., indicated Resident B was noted to have a temperature and when tested, was positive for COVID. The resident had no complaints of pain or discomfort when interacting with her. The resident was placed on isolation precautions.			

	Progress notes, dated 12/8/25 at 9:46 a.m., indicated Resident B remained in bed. She was grunting and moaning when moved. A grievance form dated 12/9/25 at 8:10 a.m., indicated the ED had responded to a call from Resident B's representative regarding lack of resident care. The form indicated, on 12/8/25 from 5:45 p.m. until 5:45 a.m., on 12/9/25, "the resident was not getting fluids as well as she had not been checked." The ED documented, cameras had been reviewed and an all-staff reminder was sent to the staff members cellphone's that ADL care was to be provided every 2 hours. The CNA in question was written up. The ED provided her cellphone number for the family representative to call during the night for any discrepancy. Progress notes, dated 12/9/25 at 9:13 a.m., 12/10/25 at 9:51 a.m., and 12/10/25 at 2:04 p.m., indicated the resident was up gotten up into a WC with staff assistance of 2, was moaning with movement, and was fed by staff who were "pushing" fluids. Review of video camera footage from Resident B's room, dated 12/10/25 at 12:06 p.m., the resident was taken from her room in a WC by staff. The resident was returned to her room at 5:51 p.m. and sat			

	beside the bed. Staff members returned and placed the resident into bed at 6:31 p.m. and provided incontinent care. During an interview on 12/16/25 at 10:30 a.m., the ED indicated she had sent out a mass text message to all staff cellphone's on 12/9/25. The message indicated, "2-hour bed checks must be done, this is not optional." The ED indicated, the message meant that all residents had to be checked. This citation relates to Intake 466670. A. Based on interview and record review, the facility failed to prevent neglect of a resident when staff delayed Cardio-Pulmonary Resuscitation (CPR) according to the resident's code status preference when a change of condition occurred, and failed to follow the CPR procedure for unresponsive residents for 1 of 3 residents reviewed for quality of care and treatment (Resident B) resulting in harm when the resident was revived with an anoxic brain injury. B. Based on interview and record review, the facility failed to prevent neglect of a resident when staff failed to monitor, assess, and provide activities of daily living (ADL - bathing, dressing, eating, using the toilet,			

	and moving [transferring/walking]) care for a resident diagnosed with COVID for at least 12 hours for 1 of 3 residents reviewed for quality of care and treatment (Resident B). Findings include: A. During an interview on 12/16/25 at 11:18 a.m., Resident B's representative indicated she was concerned with the amount of time it took staff to respond on 12/11/25 when the resident had been found unresponsive, subsequently resulting in her death later that day from an anoxic brain injury. The representative indicated Resident B had been admitted to the facility in May 2025 where she had been placed on the MC unit. The resident had been alert, could transfer and ambulate independently, could perform ADL's to include showering with oversight, she dressed herself in matching outfits, and put on her own makeup every morning. The resident had been scheduled to have a vein stent placement later in December 2025 related to a non-healing wound on the right heel that had recently caused her to have falls. On 12/11/25 at 8:30 a.m., the resident representative had received a call reporting Resident B's heart had stopped,			

	staff had initiated CPR, and the resident had been transported to the ER. The family had gone to the hospital to be with the resident who subsequently died around 2:50 p.m. Resident B's representative was upset regarding events captured by a camera inside the resident's room on 12/11/25. At approximately 7:15 a.m., the resident was woken up and taken to breakfast in a wheelchair (WC) per her normal routine. She was visibly alert with her head held up, although in great discomfort with movement as she had been for several days while recovering from COVID. At 8:20 a.m., Resident B was wheeled back into her room with her head slumping over and there was no sign of consciousness. Licensed Practical Nurse (LPN) 4 was overhead on the phone telling someone she did not think the resident had a pulse. At 8:23 a.m., the resident was transferred from the WC to bed, and she did not make a sound. For the next 7 minutes, there was great confusion as attendants were trying to determine the next steps. At 8:30 a.m., Resident B was moved from the bed to the floor where CPR was performed and around that time an ambulance was called. The resident was revived on the way to the hospital, but unfortunately sustained brain and bodily injury			

	due to oxygen deprivation. Resident B subsequently died later in the afternoon. The resident representative indicated Resident B's room was only 8 rooms from the desk, it was a short walk and should not have taken 8 minutes for the staff to verify code status and start CPR. The staff had repositioned the video camera, so that family members was unable to see any more footage to include the EMTs arriving at the resident's room. The ER staff had continued to work on Resident B after transport, but CT scans at the hospital indicated there was little to no brain activity left. Resident B's clinical record was reviewed on 12/16/25 at 10:30 a.m. Diagnoses on Resident B's profile include dementia, hypertension (high blood pressure), a history of a deep vein thrombosis (DVT - blood clot), history of taking blood thinners, peripheral vascular disease (PVD - blood vessels are narrowed or blocked), and critical limb ischemia (inadequate blood supply) of the lower right extremity. An Indiana Physician Orders for Scope of Treatment (POST) form for Resident B, dated 5/8/25, indicated if the resident had no pulse and was not breathing she wanted resuscitation/CPR. The			

	treatment goal indicated the resident wanted full interventions including life support measures in the intensive care unit. In addition to care described in comfort measures and limited additional interventions indicated the resident wanted the use of intubation, advanced airway interventions, and mechanical ventilation as needed. The resident was to be transferred to hospital and/or intensive care unit if indicated to meet medical needs. The physician order indicated the resident was a full code. A physician's order, dated 5/9/25, indicated Xarelto 10 milligrams (mg) 1 tablet daily for blood thinner. Progress notes, dated 12/11/25 at 7:01 a.m., Licensed Practical Nurse (LPN) 4 documented Resident B was assisted with morning care, gotten up from bed into a WC with transfer assistance of 2 staff, and placed in the unit common area awaiting breakfast. Progress notes, dated 12/11/25 at 9:05 a.m., LPN 4 documented Resident B had been assisted with ADL's this morning. She was up in a WC in the common area, and when the nurse went to attempt to feed the resident breakfast, the resident was found			

	unresponsive. Oxygen saturations were 62% and her skin was cool to touch. CPR was initiated, 911 was called, and the Executive Director (ED) and Director of Nursing (DON) were notified. Resident B was left in care of paramedics upon their arrival. The daughter was notified and the resident was transferred to a local hospital. A Progress Notes, dated 12/11/25 at 3:37 p.m., the DON documented a care manager from a local hospital called to notify the DON that Resident B had passed away at 2:42 p.m. with a diagnosis of cardiac arrest. Observation of a sign posted on the outside of Resident B's locked door indicated, "Ring camera in use. This is how she communicates with family. Feel free to cover temporarily if needed to preserve dignity." The resident's room was 8 doors from the center of the memory care (MC) unit where the nurse's station was located.			

	Resident B's hard chart was observed on a shelf inside the nurse's station door. There was a green label on the outside spine of the chart with the resident's name, room number, and name of the physician. The green label indicated the resident's code status was full code. Review of video camera footage from Resident B's room, dated 12/11/25, included: a. At 5:49 a.m., an unidentified staff member was observed to enter the resident's room to provide incontinence care. The resident could be overheard moaning as she was moved during care. b. At 5:51 a.m. the unidentified staff member left the room. c. At 6:54 a.m. Certified Nursing Assistant (CNA) 6 was observed to enter the resident's room to provide morning care. LPN 4 and CNA 6 were observed transferring the resident into a manual WC. The resident could be overheard moaning with any movement of her body. d. At 7:12:39 a.m. the resident was wheeled from the room by CNA 6. The resident was alert and sitting up straight in the WC looking around. e. At 8:20:55 a.m. the resident was observed being wheeled			

back into her room in a WC, her head was resting on her chest, her extremities were lax, and she was unresponsive. When the WC was turned to be positioned by the bed, the resident's right foot rubbed against the bed, and the resident did not react. Staff left the room for approximately 1 minute, leaving the resident alone.

f. At 8:22:52 a.m., LPN 4 was observed making a call on her cellphone at bedside.

g. At 8:23:49 a.m. The resident was transferred into the bed and covered with blankets to her chest. CNA 7 placed her hand on the resident's forehead above her eyes and stroked her hand down towards the resident's nose as if to close the resident's eyelids.

h. At 8:25:37 a.m. LPN 4 and LPN 5 were observed listening to the resident's chest with a stethoscope, they felt for a pulse at the carotid artery, and LPN 4 (the only CPR certified nurse on duty) left the room.

i. At 8:25:50 a.m. LPN 5 was observed feeling for pedal pulses and was heard asking CNA 6 and Home Health Aide (HHA) 7 if the resident was a full code status and referred to the sign taped at the back of the door.

	j. At 8:26:07 a.m., full code status was verified by the blue sign on the back of the resident's door. k. At 8:28:22 a.m. - 8:31:11 a.m. all staff members were observed to leave the room. The resident was left alone, and she was not seen moving or making noise from the bed. l. At 8:31:46 a.m., LPN 4, LPN 5, CNA 6, and HHA 7 were observed to reenter the room, and the resident was moved to the floor at bedside. m. At 8:31:50 a.m., LPN 4 initiated CPR on the resident. CNA 4 was observed to then turn the camera over which caused the recording to stop. Facility surveillance video camera footage of Resident B in the dining room and main hallway, dated 12/11/25, was reviewed with the ED and included: a. At 7:14 a.m., Resident B was brought to the dining room and placed at a table with two other residents. The resident was alert and looking around. b. At 7:18:26 a.m., the resident was moved to the lounge area beside the dining room. The resident was positioned facing the main hallway within 6 feet of dining tables where other residents were served drinks			

and breakfast.

c. At 7:19:50 a.m., LPN 4 was observed to offer the resident a drink.

d. From 7:24:36 a.m. to 7:50 a.m., the resident was observed to periodically move her hands around and off her lap.

e. At 8:05:20 a.m., the resident was observed with a slight head movement. This was the last time the resident was observed moving her head.

f. At 8:18:53 a.m., LPN 4 was observed tapping the resident, saying something to her, and clipping a pulse oximeter to her finger.

g. At 8:20:14 a.m., Resident B was observed being pushed from the dining room by LPN 4, as CNA 6 and HHA 7 followed. The resident's chin was resting on her chest, and she was unresponsive.

h. At 8:29:30 a.m., CNA 6 and HHA 7 were observed walking down the hallway towards the dining room, their movements were unhurried.

i. At 8:31:06 a.m., LPN 4, LPN 5, CNA 6, and HHA 7 were observed hurrying down the hallway and entering Resident B's room.

j. At 8:32:10 a.m., two firemen

arrived at the unit.

k. At 8:33:29 a.m., LPN 4 and CNA 6 left the resident's room.

l. At 8:34:25 a.m., Emergency Medical Services (EMS) arrived at the unit.

m. At 8:38 a.m., LPN 5 left the resident's room.

n. At 8:45 a.m., the DON arrived at the unit.

o. At 8:50:33 a.m., Resident B was seen on a gurney leaving the facility with EMS. She was intubated, and a LUCUS device (Life Under Chest Compressions Assist System - a portable, battery-operated device that provides automated, consistent chest compressions for patients in cardiac arrest) was moving on her chest.

A local Fire Department EMS report, dated 12/11/25, indicated they had been called to assist with an unconscious resident with signs and symptoms of cardiac arrest. Upon arrival the resident was found pulseless and apneic (stopped breathing) in her room. Facility staff had reported the patient had been found unresponsive approximately 8 -10 minutes prior to EMS arrival, and CPR was in progress by healthcare staff upon EMR arrival. Fire station staff had arrived just prior and had taken

over CPR. First vitals were recorded at 8:38 a.m., indicated unable to obtain blood pressure (BP), pulse 61 beats per minute and respirations 13 per minute. The resident was in cardiac arrest, her eyes dilated, skin mottled, and no pulses were found in the lower extremities. EMS provided care to include oxygen, orotracheal intubation, intravenous (IV) therapy and bolus of fluids, epinephrine (adrenaline) times 5 doses, CPR, and mechanical CPR. EMS arrived at a local hospital emergency department (ED) at 8:57 a.m. and transferred care to the hospital staff.

A local hospital report, dated 12/11/25 at 9:13 a.m., indicated history obtained by EMS included, Resident B was reportedly last seen in her normal state of health at approximately 8:12 a.m. The resident was found unresponsive by facility staff at approximately 8:26 a.m., at which time CPR was started. EMS stated they arrived on scene at 8:32 a.m. and continued compressions and ultimately placed a LUCUS device. Code status on arrival was full code. Upon arrival 3 units of packed red blood cells (PRBC) was given, she was on a ventilator, and 3 vasopressors were started. The initial assessment plan included acute respiratory failure with hypoxia

	and hypercarbia, blood loss anemia, cardiac arrest, and gastrointestinal (GI) bleed. The neuro assessment indicated anoxic brain injury (where the brain is completely deprived of oxygen, often from events like cardiac arrest). Computed Tomography (CT scan - detailed cross-sectional [slices] of the body, showing bones, organs, soft tissue, and blood vessels) of the abdomen/pelvis indicated occluded right common iliac and right external iliac artery stent. CT of the chest indicated no pulmonary artery embolism. CT scan of the head indicated no evidence of acute hemorrhage. X-ray of the chest indicated no acute cardiopulmonary findings. Multiple bilateral nondisplaced rib fractures and a nondisplaced sternal fracture. A local hospital addendum report, dated 12/12/25 at 8:49 a.m., indicated extended care Resident B had presented to the hospital after being found down at her facility, last known normal approximately 15 minutes prior to being found. She was pulseless, had CPR initiated. The patient received approximately 32 minutes of CPR prior to hospital arrival and an additional 22 minutes after arrival at the hospital, before return of ROSC (return of spontaneous circulation). Patient is status post prolonged resuscitative efforts with			

	evidence of multisystem organ failure, encephalopathy consistent with anoxic injury, she received PRBC for concern of GI bleed although she did not appear to have ongoing brisk bleed, acute renal failure, and likely an ischemic bowel due to severe vascular disease and hypoperfusion state (inadequate blood flood to tissues leading to oxygen deprivation). Prognosis for survival was very poor. During an interview on 12/16/25 at 12:34 p.m., the DON indicated she had received a call on 12/11/25 regarding Resident B. LPN 4 reported Resident B was not breathing and non-responsive, and she had initiated CPR and was calling 911. When the DON arrived at the facility, EMS staff were in the resident's room performing CPR and then shortly after transported her to a local hospital. Resident B's code status had been full code. The code status could have been found on a POST form in the hard chart, which was stored at the nurse's station. Labels on the outside of the chart were color coded, green for full code, and red for DNR (do not resuscitate.) During an interview on 12/16/25 at 1:36 p.m., HHA 7 indicated on 12/11/25, she was not assigned to take care of Resident B. CNA 6 had gotten			

	the resident up and put her at the assistance table in the dining room. HHA 7 then made Resident B a small cup of coffee, but the resident did not interact or drink her coffee. LPN 4 or CNA 6 had then moved the resident to the lounge at the side of the dining room in front of the TV. At some point later, HHA 7 had heard LPN 4 repeatedly calling Resident B's name and saw her taking her vital signs. LPN 4 took the resident to her room and instructed HHA 7 to get another nurse. When she returned, HHA 7 and CNA 6 helped put Resident B back into bed, the resident was still not responding at that time. HHA 7 then left to go watch the residents who were eating breakfast. During an interview on 12/16/25 at 1:47 p.m., LPN 4 indicated, on 12/11/25, she had been working on the MC unit which was her normal assignment. Resident B had been dealing with COVID and had not been feeling well. On 12/11/25 LPN 4 had assisted with getting the resident out of bed into a WC, and then around 7:30 a.m., the resident had been placed in front of the TV in the lounge by the dining room as she awaited breakfast. The resident had a cup of liquid next to her, but she was not drinking it. LPN 4 passed some medications and then when she went to get the			

	resident, she did not respond to her greeting, and her hand was cold to the touch. Oxygen saturations were reading 66%, the resident was still not responding to their voices or touch, so staff were called to help take the resident back to her room. LPN 4 went to the nurse's office to check the chart for code status, summoned LPN 5 from the other side of the facility, placed Resident B on the floor and started CPR. LPN 4 indicated she had called the ED from her cellphone as she went down the hallway and called 911 from the office phone while LPN 5 stayed in the room with the resident. LPN 4 initiated CPR after she returned to the resident's room, and she had called the resident's daughter while EMS was working on the resident. During an interview on 12/16/25 at 2:00 p.m., CNA 6 indicated, on 12/11/25, she had gotten Resident B up for breakfast with the help of LPN 4, and the resident had been making grunting noises with movement. HHA 7 had made the resident some coffee as she liked it, but she did not drink it. Resident B had initially been sat at the feeding assistance table but then was moved in front of the TV at the nurse's request. CNA 6 then helped serve breakfast to the other residents. At one point she heard LPN 4 calling			

	Resident B's name but there was no response. LPN 4 and CNA 6 took the resident back to her room and she was put into bed. The resident was unresponsive the whole time and did not make any noise. Resident B's husband could see the resident on the camera in the resident's room and started yelling at staff from the camera questioning what was happening to his wife. CNA 6 indicated she had turned the camera upside down so the husband would not have to see the resident being cared for and having CPR. LPN 4 and CNA 6 placed the resident on the floor, LPN 5 was summoned to the room via walkie talkie, and LPN 4 was performing CPR when LPN 5 arrived at the room. CNA 6 indicated she had left the room to help monitor breakfast while LPN 4 did CPR. EMS arrived and took over CPR, and the resident was taken to the hospital. During an interview on 12/16/25 at 2:16 p.m., LPN 5 indicated, on 12/11/25 around 8:00 a.m., she had been called via walkie talkie to go to the MC unit. She was not sure of the time, but she had been passing medications. When she arrived at the unit, Resident B had been sitting in a WC at bedside in her room, and she was unresponsive. LPN 5 was told the resident had been found			

	unresponsive and the nurse had already called 911. Staff members then put the resident to bed where the nurses checked for pulses without success. There was a blue sign on the back of the resident's door that indicated full code, but LPN 4 also went to the nurse's station to check for code status. Code status could be identified by the green label on the hard chart or by a POST form in the chart. After LPN 4 returned to the room, Resident B was placed on the floor and LPN 4 initiated CPR. LPN 5 left soon after and returned to her unit, she had not been present when the resident left via ambulance for the hospital. LPN 5 indicated she was not aware there had been a camera in the room. During an interview on 12/18/25 at 11:46 a.m., the ED indicated a resident's code status could be identified by visualizing the color of the resident nametag on the outside of the chart. The tag would be green for full code or perform CPR, or red for No Code or DNR. The ED indicated, to her knowledge, there never was colored paper on the back of the residents' doors that would signify a code status. During an interview on 12/18/25 at 12:44 p.m., LPN 4 indicated a resident's code status could be found in the electronic medical			

	record (EMR) on the face sheet, in the physician's orders, by the color-coded name label on the spine of the hand chart inside the nurse's station, or on an advanced directive form or POST form in the hard chart. When a resident was found unresponsive, CPR should be started as soon as possible after the code status was confirmed, maybe a couple of minutes. LPN 4 indicated, she thought everyone working in the MC unit was CPR certified. During an interview on 12/18/25 at 1:25 p.m., the ED indicated, on 12/11/25, Resident B had been taken from the lounge beside the dining room back to her room at 8:20 a.m., and CPR was not started until 8:31 a.m. The expectation would be for CPR to be started immediately. The ED indicated that not every staff member was expected to have CPR certification, although sessions were offered for all nursing staff. The ED indicated she did not know in an emergency situation how the staff working in the facility would know who was certified in CPR. The staff member should call the lead nurse on duty for guidance. The ED indicated the facility had no policy for CPR guidance. The facility followed the State regulation for Licensed Residential of "A minimum of			

	one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times." On 12/18/25 at 11:46 a.m., the ED provided a Code Status policy, dated 6/14, and indicated the policy was the one currently being used by the facility. The policy indicated, "It is the policy of this community that all residents will have upon admission a code status established. Procedure. 1. At the time of admission, the Executive Director/Leasing Director will sign admission paperwork with the resident or resident's representative. 2. The Resident Clinical Director will give to the resident or resident representative the Advanced Directives Acknowledgement Form. 3. If the resident chooses to formulate and issue the advanced directive for Do Not Resuscitate, the Resident Clinical Director will complete the discussion for Do Not Resuscitate. 4. The Do Not Resuscitate form is completed by the resident and/or representative and a copy given to the resident. 5. The Do Not Resuscitate Form is then given to the Resident Clinical Director to fax to the physician for signature. 6. When the form is signed by both the resident and/or representative and the physician, it is then placed in the resident's chart in the Advanced			

	Directive section." B. During an interview on 12/16/25 at 11:18 a.m., Resident B's representative indicated on 12/4/25, Resident B had tested positive for COVID and placed in isolation where the family was not allowed to visit. On 12/8/25, a home health nurse had visited to provide wound treatments on the resident's right foot and left lower leg, and during her visit had found the resident's oxygen level around 88% and the resident becoming dehydrated. The resident was not given an oxygen order at that time, but staff hand fed her in her room and were pushing fluids. The video camera footage showed the staff beginning to put the resident to that night around 6:00 p.m., and the staff did not check on the resident for 12 hours when someone entered around 6:00 a.m. on 12/9/25 to change her brief. Another staff member entered the room on 12/9/25 around 8:00 a.m. to offer the resident breakfast, meaning the resident had been approximately 14 hours without being offered food or drinks when they knew she was becoming dehydrated. During the night around 2:00 a.m., the resident representative had attempted twice to call staff to check on the resident, but there was no answer to her phone calls. On 12/9/25, Resident B's			

	representative had called the ED to report her concerns about the night staff not checking the resident all night, and the ED had acknowledged effort from the prior day to hydrate and feed the resident had been negated. On 12/9/25 staff had taken the resident to the dining room and attempted to feed her breakfast, but she had been in pain, and they had gotten her up in a chair for a bit, but she just wanted to sleep all day. On 12/10/25 Resident B was gotten up and taken out of her room to the main area through dinner without being brought back to her room to rest or change her brief. At that point the family thought the resident must have been doing better because she had been left up all day. Resident B's clinical record was reviewed on 12/16/25 at 10:30 a.m. Diagnoses on Resident B's profile include dementia, hypertension (high blood pressure), a history of a deep vein thrombosis (DVT - blood clot), history of taking blood thinners, peripheral vascular disease (PVD - blood vessels are narrowed or blocked), and critical limb ischemia (inadequate blood supply) of the lower right extremity. Progress notes, dated 12/4/25 at 10:00 a.m., indicated Resident B was noted to have a temperature and when tested,			

	was positive for COVID. The resident had no complaints of pain or discomfort when interacting with her. The resident was placed on isolation precautions. Progress notes, dated 12/8/25 at 9:46 a.m., indicated Resident B remained in bed. She was grunting and moaning when moved. A grievance form dated 12/9/25 at 8:10 a.m., indicated the ED had responded to a call from Resident B's representative regarding lack of resident care. The form indicated, on 12/8/25 from 5:45 p.m. until 5:45 a.m., on 12/9/25, "the resident was not getting fluids as well as she had not been checked." The ED documented, cameras had been reviewed and an all-staff reminder was sent to the staff members cellphone's that ADL care was to be provided every 2 hours. The CNA in question was written up. The ED provided her cellphone number for the family representative to call during the night for any discrepancy. Progress notes, dated 12/9/25 at 9:13 a.m., 12/10/25 at 9:51 a.m., and 12/10/25 at 2:04 p.m., indicated the resident was up gotten up into a WC with staff assistance of 2, was moaning with movement, and was fed by staff who were "pushing" fluids.			

	Review of video camera footage from Resident B's room, dated 12/10/25 at 12:06 p.m., the resident was taken from her room in a WC by staff. The resident was returned to her room at 5:51 p.m. and sat beside the bed. Staff members returned and placed the resident into bed at 6:31 p.m. and provided incontinent care. During an interview on 12/16/25 at 10:30 a.m., the ED indicated she had sent out a mass text message to all staff cellphone's on 12/9/25. The message indicated, "2-hour bed checks must be done, this is not optional." The ED indicated, the message meant that all residents had to be checked. This citation relates to Intake 466670.			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at	R 0117		01/06/2026

	all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure a Qualified Medication Aide (QMA) had not acted outside of her scope of practice by administering nebulizer treatments for 1 of 5 residents reviewed for nebulizer treatments (Resident E). Findings include: A clinical record review for Resident E was completed on 12/16/25 at 2:30 p.m. Diagnoses included chronic obstructive pulmonary disease.			

	A current physician's order, indicated to administer levalbuterol (to prevent or treat bronchospasm) 1.25 mg (milligram) per 3 ml (milliliter) solution twice at day at 8:00 a.m. and 8:00 p.m. via a nebulizer machine. A review of the resident's administration record indicated QMA 8 had administered the 8:00 p.m. nebulizer treatments on 12/2/25, 12/6/25, 12/7/25, 12/11/25, and 12/13/25. During an interview on 12/16/25 at 2:05 p.m., Resident E indicated the staff put the liquid in the nebulizer and turn on the machine when he gets a treatment. They put the breathing device in his mouth and when the treatment was done, he turned the machine off and laid the tubing on the side table. The staff returned at a later time and rinsed out the tubing and placed it to dry. During a telephone interview on 12/18/25 at 1:47 p.m., QMA 8 indicated she was not aware it was outside of her scope of practice to administer nebulizer treatments, and had completed them many times if ordered by the physician. During an interview on 12/16/25 at 1:45 p.m., the Administrator indicated she had reviewed the QMA Scope of Practice and			

read that nebulizer treatments were not to be administered by a QMA. However, she felt the residents at the facility were assisted living and were able to turn on and off the nebulizer machines. The QMAs followed the physician's orders and placed the solution into the reservoir for the resident to turn on the machine and administer the treatment.

A current facility policy, undated, titled, "Qualified Medication Aide Scope of Practice," provided by the Administrator on 12/18/25 at 9:38 a.m., included the following: "...The following tasks shall NOT be included in the QMA scope of practice:...(2) Administer medication used for intermittent positive pressure breathing (IPPD) treatments of any form of medication inhalation treatments, such as nebulizers...."

This citation relates to Intake 466332.

Based on interview and record review, the facility failed to ensure a Qualified Medication Aide (QMA) had not acted outside of her scope of practice by administering nebulizer treatments for 1 of 5 residents reviewed for nebulizer treatments (Resident E).

Findings include:

A clinical record review for

Resident E was completed on 12/16/25 at 2:30 p.m. Diagnoses included chronic obstructive pulmonary disease.

A current physician's order, indicated to administer levalbuterol (to prevent or treat bronchospasm) 1.25 mg (milligram) per 3 ml (milliliter) solution twice at day at 8:00 a.m. and 8:00 p.m. via a nebulizer machine.

A review of the resident's administration record indicated QMA 8 had administered the 8:00 p.m. nebulizer treatments on 12/2/25, 12/6/25, 12/7/25, 12/11/25, and 12/13/25.

During an interview on 12/16/25 at 2:05 p.m., Resident E indicated the staff put the liquid in the nebulizer and turn on the machine when he gets a treatment. They put the breathing device in his mouth and when the treatment was done, he turned the machine off and laid the tubing on the side table. The staff returned at a later time and rinsed out the tubing and placed it to dry.

During a telephone interview on 12/18/25 at 1:47 p.m., QMA 8 indicated she was not aware it was outside of her scope of practice to administer nebulizer treatments, and had completed them many times if ordered by the physician.

	During an interview on 12/16/25 at 1:45 p.m., the Administrator indicated she had reviewed the QMA Scope of Practice and read that nebulizer treatments were not to be administered by a QMA. However, she felt the residents at the facility were assisted living and were able to turn on and off the nebulizer machines. The QMAs followed the physician's orders and placed the solution into the reservoir for the resident to turn on the machine and administer the treatment. A current facility policy, undated, titled, "Qualified Medication Aide Scope of Practice," provided by the Administrator on 12/18/25 at 9:38 a.m., included the following: "...The following tasks shall NOT be included in the QMA scope of practice:...(2) Administer medication used for intermittent positive pressure breathing (IPPD) treatments of any form of medication inhalation treatments, such as nebulizers...." This citation relates to Intake 466332.			
R 0118	Personnel - Deficiency 410 IAC 16.2-5-1.4(c) (c) Any unlicensed employee providing more than limited assistance with the activities of daily living must be either a	R 0118		01/06/2026

certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse aide or a home health aide.

Based on record review and interview, the facility allowed a Certified Nursing Aide to complete resident care with an expired license for 1 of 53 employees reviewed for active licensure (CNA 6).

Findings include:

During Employee Record Review, CNA 6's certified nurse aide license was indicated as expired on 11/24/25 on the MyLicense.IN.gov website, accessed on 12/16/25 at 11:20 a.m.

According to staffing schedules, CNA 6 had worked as a CNA, providing resident care, following the expiration of her licensure on 11/26/25, 11/27/25, 12/2/25, 12/4/25, 12/5/25, 12/8/25, 12/11/25, 12/12/25, and 12/16/25.

During an interview on 12/18/25 at 11:34 a.m., the Administrator indicated CNA 6's license had expired and she had been working with residents, providing care. She should not

	have been working and providing resident care. No policy was provided. This citation relates to Intake 466332. Based on record review and interview, the facility allowed a Certified Nursing Aide to complete resident care with an expired license for 1 of 53 employees reviewed for active licensure (CNA 6). Findings include: During Employee Record Review, CNA 6's certified nurse aide license was indicated as expired on 11/24/25 on the MyLicense.IN.gov website, accessed on 12/16/25 at 11:20 a.m. According to staffing schedules, CNA 6 had worked as a CNA, providing resident care, following the expiration of her licensure on 11/26/25, 11/27/25, 12/2/25, 12/4/25, 12/5/25, 12/8/25, 12/11/25, 12/12/25, and 12/16/25. During an interview on 12/18/25 at 11:34 a.m., the Administrator indicated CNA 6's license had expired and she had been working with residents, providing care. She should not have been working and providing resident care.			

	No policy was provided. This citation relates to Intake 466332.			
R 0246	Health Services - Deficiency 410 IAC 16.2-5-4(e)(6) (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on record review and interview, the facility failed to assure a Qualified Medication Aide (QMA) obtained authorization from a licensed nurse prior to administering an as needed (PRN) medication, and/or complete documentation of the contact with a licensed nurse regarding the authorization given for 1 of 5 residents reviewed for medication administration (Resident D). Finding includes: The clinical record for Resident D was reviewed on 12/16/25 at	R 0246		01/06/2026

1:26 p.m. Diagnoses included chronic heart failure, end stage renal disease, and osteoarthritis.

A current physician's order, dated 11/25/25, indicated to administer lorazepam intensol (to treat anxiety) oral concentrate 2 mg (milligram) per ml (milliliter), 0.25 ml every four hours as needed for anxiety or restlessness.

Review of the eMAR indicated the following:

a. The medication had been administered by QMA 8, on 12/6/25 at 9:31 p.m. for anxiety. The outcome indicated the medication was effective. The clinical record lacked indication a licensed nurse had been contacted for authorization or a co-signature present for the approval to administer the medication.

b. The medication had been administered by QMA 8 on 12/7/25 at 9:24 a.m. for anxiety; nurse notified. The outcome indicated the medication was effective. The clinical record lacked a co-signature for the approval to administer the medication.

A current physician's order, dated 11/25/25, indicated to administer morphine sulfate (to treat pain) Oral Solution 20 mg/ml, 0.25 ml every four hours

as needed for pain or shortness of breath.

Review of the eMAR indicated the following:

a. The medication had been administered by QMA 8, on 12/6/25 at 7:02 p.m. for shortness of breath and discomfort. The outcome indicated the medication was effective. The clinical record lacked indication a licensed nurse had been contacted for authorization or a co-signature present for the approval to administer the medication.

b. The medication had been administered by QMA 8, on 12/7/25 at 9:24 a.m. for anxiety; nurse notified. The outcome indicated the medication was effective. The clinical record lacked a co-signature for the approval to administer the medication.

During an interview on 12/18/25 at 1:32 p.m., the Director of Nursing (DON) indicated there was no area for the licensed nurse to co-sign a PRN administration of a medication that she had given approval to be administered. There was currently no place in the clinical record where the licensed nurses would co-sign for an administration of PRN medication.

A current facility policy, revised

	1/1/14, titled, "Qualified Medication Aide," provided by the Administrator on 12/18/25 at 9:38 a.m., included the following: "...Essential Position Functions...Administers as allowed, PRN drugs when authorized by a licensed nurse....Keeps medical records current by charting pertinent resident conditions timely and routine charged as scheduled, with co-signature by licensed nurse." A current facility policy, undated, titled, "Qualified Medication Aide Scope of Practice," provided by the Administrator on 12/18/25 at 9:38 a.m., included the following: "The following tasks are within the scope of practice for the QMA unless prohibited by facility policy....(11) Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or on call. If authorization is obtained, the QMA must to the following....(B) Document in the resident record that the facility's licensed nurse was contacted, symptoms described, and permission was granted to administer the medication, including the time of contact....(D) Ensure that the resident's record is cosigned by the licensed nurse who gave permission by the end of the nurse's shift, or if the nurse was on call, by the end of the nurse's			

	next tour of duty." This citation relates to Intake 466332. Based on record review and interview, the facility failed to assure a Qualified Medication Aide (QMA) obtained authorization from a licensed nurse prior to administering an as needed (PRN) medication, and/or complete documentation of the contact with a licensed nurse regarding the authorization given for 1 of 5 residents reviewed for medication administration (Resident D). Finding includes: The clinical record for Resident D was reviewed on 12/16/25 at 1:26 p.m. Diagnoses included chronic heart failure, end stage renal disease, and osteoarthritis. A current physician's order, dated 11/25/25, indicated to administer lorazepam intensol (to treat anxiety) oral concentrate 2 mg (milligram) per ml (milliliter), 0.25 ml every four hours as needed for anxiety or restlessness. Review of the eMAR indicated the following: a. The medication had been administered by QMA 8, on 12/6/25 at 9:31 p.m. for anxiety.			

The outcome indicated the medication was effective. The clinical record lacked indication a licensed nurse had been contacted for authorization or a co-signature present for the approval to administer the medication.

b. The medication had been administered by QMA 8 on 12/7/25 at 9:24 a.m. for anxiety; nurse notified. The outcome indicated the medication was effective. The clinical record lacked a co-signature for the approval to administer the medication.

A current physician's order, dated 11/25/25, indicated to administer morphine sulfate (to treat pain) Oral Solution 20 mg/ml, 0.25 ml every four hours as needed for pain or shortness of breath.

Review of the eMAR indicated the following:

a. The medication had been administered by QMA 8, on 12/6/25 at 7:02 p.m. for shortness of breath and discomfort. The outcome indicated the medication was effective. The clinical record lacked indication a licensed nurse had been contacted for authorization or a co-signature present for the approval to administer the medication.

b. The medication had been

	administered by QMA 8, on 12/7/25 at 9:24 a.m. for anxiety; nurse notified. The outcome indicated the medication was effective. The clinical record lacked a co-signature for the approval to administer the medication. During an interview on 12/18/25 at 1:32 p.m., the Director of Nursing (DON) indicated there was no area for the licensed nurse to co-sign a PRN administration of a medication that she had given approval to be administered. There was currently no place in the clinical record where the licensed nurses would co-sign for an administration of PRN medication. A current facility policy, revised 1/1/14, titled, "Qualified Medication Aide," provided by the Administrator on 12/18/25 at 9:38 a.m., included the following: "...Essential Position Functions...Administers as allowed, PRN drugs when authorized by a licensed nurse....Keeps medical records current by charting pertinent resident conditions timely and routine charged as scheduled, with co-signature by licensed nurse." A current facility policy, undated, titled, "Qualified Medication Aide Scope of Practice," provided by the Administrator on 12/18/25 at			

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R 0296	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(b) (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on observation, interview	R 0296		01/06/2026

and record review, the facility failed to ensure staff were trained on proper technique when administering insulin using an insulin pen for 1 of 1 residents observed for insulin administration (Resident D).

Findings include:

During a medication administration observation for Resident D on 12/16/25 at 11:19 a.m., LPN 5 obtained an insulin pen and needle from the medication cart. Upon entering the resident's room, LPN 5 dialed the ordered dose of insulin to "5" and administered the dose into the resident's abdomen. She had not primed the new needle prior to administration. During an interview upon returning to the medication cart, LPN 5 had indicated she did not prime the needle prior to administering insulin when using a pen. She had worked as an LPN for a long time and had never been instructed to do so. She was unaware of a need to prime the insulin needle when using an insulin pen.

Review of the resident's clinical record was completed on 12/16/25 at 2:10 p.m. Diagnoses included diabetes mellitus-type II and mild cognitive impairment.

A current physician's order,

dated 12/2/25, indicated to administer Novolog (to treat diabetes mellitus) FlexPen per sliding scale with meals.

During an interview on 12/16/25 at 1:36 p.m., the Director of Nursing (DON) indicated LPN 5 should have primed the needle prior to dialing the ordered dose and administering the insulin when using an insulin pen.

A current facility policy, dated 9/12/25, titled, "Insulin Administration," provided by the Administrator on 12/18/25 at 11:36 a.m., indicated the following: "...Procedure:...If using an insulin pen: ...8. Apply new pen needle 9. Set the dial to 2 units 10. Holding the pen with the needles pointing upwards, tab {SIC} the pen to move air bubbles to the top 11. Press the injection button fully until the dose window returns to "0". Ensure you see an insulin drop leave the needle. 12. Dial the dose to correct unit."

This citation relates to Intake 466332.

Based on observation, interview and record review, the facility failed to ensure staff were trained on proper technique when administering insulin using an insulin pen for 1 of 1 residents observed for insulin administration (Resident D).

Findings include:

During a medication administration observation for Resident D on 12/16/25 at 11:19 a.m., LPN 5 obtained an insulin pen and needle from the medication cart. Upon entering the resident's room, LPN 5 dialed the ordered dose of insulin to "5" and administered the dose into the resident's abdomen. She had not primed the new needle prior to administration. During an interview upon returning to the medication cart, LPN 5 had indicated she did not prime the needle prior to administering insulin when using a pen. She had worked as an LPN for a long time and had never been instructed to do so. She was unaware of a need to prime the insulin needle when using an insulin pen.

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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