STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS AT HUNTER STATION	400 HUNTER STATION ROAD, SELLERSBURG, , 47172

(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 467955. Intake 467955 - State deficiencies related to the allegations are cited at R0247 and R0297 Survey dates: March 3 and 4, 2026 Facility number: 013841 Residential Census: 106 These State Residential Findings are cited accordance with 410 IAC 16.2-5. Quality review completed on March 6, 2026.	R 0000	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion stated on the statement of deficiencies. The statement of correction is prepared and submitted solely because of requirements under state and federal laws. We cordially request a desk review regarding the alleged deficiencies in lieu of a revisit.	
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	R 0247	**R247** **Corrective Action(s) for Residents Affected by the Deficient Practice**	03/27/2026

	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 a resident's (Resident E) blood pressure medication was held, as ordered by the physician, when out of parameters, for 1 of 3 residents reviewed for medication errors. Findings include: The clinical record for Resident E was reviewed on 3/3/26 at 11:27 a.m. The resident's diagnosis included, but was not limited to, hypertension (high blood pressure). The physician's order, with a start date of 12/6/24, indicated the resident was to receive Isosorbide mononitrate (medication for high blood pressure), 60 mg (milligrams) extended release tablet, daily at 8:00 a.m. The medication was to be held if the resident's systolic blood pressure (top number) was less than 120.		Residents E medication orders including parameters were reviewed by Primary care physician by 3/20/2026 and resident's service plan remains current at this time. **Corrective Action(s) for Other Residents Potentially Affected** Other residents have the potential to be affected by this deficient practice; however, none were affected. Residents with physician orders involving parameters for medication administration were reviewed by clinical team to ensure resident's order remain current. **Measures to Ensure the Deficient Practice Does Not Recur** Wellness Director, Memory Care Director and Unit Coordinator will be educated by Regional Nurse on 3/16/2026 to include the Medication Administration policy and following physician orders. Wellness Director and/or designated nurse will educate nurses on or before 3/26/2026 on the Medication Administration policy including following physician orders. Newly hired nurses will be educated during orientation ongoing. Wellness Director and/or designated nurse will review new physician orders with parameters during daily	

	Review of the November 2025 medication administration record (MAR) indicated the resident was administered the medication on the following dates when the resident's systolic blood pressure was below 120: -On 11/04/25, when the resident's systolic blood pressure was 116. Review of the December 2025 MAR indicated the resident was administered the medication (Isosorbide mononitrate) on the following dates when the resident's systolic blood pressure was below 120: -On 12/02/25, the resident was administered Isosorbide mononitrate when the resident's systolic blood pressure was 116. -On 12/11/25, the resident was administered Isosorbide mononitrate when the resident's systolic blood pressure was 101. -On 12/15/25, the resident was administered Isosorbide mononitrate when the resident's systolic blood pressure was 116. -On 12/22/25, the resident was administered Isosorbide mononitrate when the resident's systolic blood pressure was		clinical meeting as well as alerts triggered when vitals are not within range. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The Executive Director and/or designee will complete an audit of resident physician order that include parameters to ensure physician orders are being followed for medication administration. The audits will be conducted for 5 resident physician orders that include parameters weekly for 4 weeks, then 3 resident physician orders weekly for 4 weeks, then 1 resident physician order weekly for 4 weeks. The Executive Director will review results of the audits at the monthly QA meeting. The Quality Assurance committee will determine the need for further revisions or corrective actions as well as a need to change the frequency and length of continued audits.	

	111. -On 12/26/25, the resident was administered Isosorbide mononitrate when the resident's systolic blood pressure was 110. -On 12/31/25, the resident was administered Isosorbide mononitrate when the resident's systolic blood pressure was 119. Review of the January 2026 MAR indicated the resident was administered the medication on the following dates when the resident's systolic blood pressure was below 120: -On 1/06/26, the resident was administered Isosorbide mononitrate when the resident's systolic blood pressure was 109. -On 1/12/26, the resident was administered Isosorbide mononitrate when the resident's systolic blood pressure was 110. -On 1/19/26, the resident was administered Isosorbide mononitrate when the resident's systolic blood pressure was 107. -On 1/21/26, the resident was administered Isosorbide mononitrate when the resident's systolic blood pressure was			

	112. -On 1/22/26, the resident was administered Isosorbide mononitrate when the resident's systolic blood pressure was 114. Review of the February 2026 MAR indicated the resident was administered the medication on the following dates when the resident's systolic blood pressure was below 120: -On 2/10/26, the resident was administered Isosorbide mononitrate when the resident's systolic blood pressure was 111. -On 2/12/26, the resident was administered Isosorbide mononitrate when the resident's systolic blood pressure was 110. -On 2/18/26, the resident was administered Isosorbide mononitrate when the resident's systolic blood pressure was 116. -On 2/23/26, the resident was administered Isosorbide mononitrate when the resident's systolic blood pressure was 112. The physician's order, with a start date of 12/6/24, indicated the resident was to receive Carvedilol (medication for high			

	blood pressure), 6.25 mg twice daily at 8:00 a.m. and 8:00 p.m. for hypertension. The medication was to be held for a systolic blood pressure less than 120 and/or pulse (heart rate) less than 60. Review of the November 2025 MAR indicated the resident was administered the medication on the following dates and times when the resident's systolic blood pressure was below 120 or the resident's pulse was less than 60: -On 11/04/25 at 8:00 a.m., the resident was administered Carvedilol when the resident's systolic blood pressure was 116. -On 11/07/25 at 8:00 p.m., the resident was administered Carvedilol when the resident's systolic blood pressure was 117. -On 11/14/25 at 8:00 p.m., the resident was administered Carvedilol when the resident's systolic blood pressure was 118. -On 11/17/25 at 8:00 p.m., the resident was administered Carvedilol when the resident's systolic blood pressure was 118. -On 11/30/25 at 8:00 p.m., the resident was administered			

	Carvedilol when the resident's pulse was 57. Review of the December 2025 MAR indicated the resident was administered the medication on the following dates and times when the resident's systolic blood pressure was below 120 or the resident's pulse was less than 60: -On 12/02/25 at 8:00 a.m., the resident was administered Carvedilol when the resident's systolic blood pressure was 116 and the resident's pulse was 59. -On 12/15/25 at 8:00 a.m., the resident was administered Carvedilol when the resident's systolic blood pressure was 118. -On 12/22/25 at 8:00 a.m., the resident was administered Carvedilol when the resident's systolic blood pressure was 111. -On 12/28/25 at 8:00 a.m., the resident was administered Carvedilol when the resident's systolic blood pressure was 110. -On 12/31/25 at 8:00 a.m. the resident was administered Carvedilol when the resident's systolic blood pressure was 119. Review of the January 2026			

	MAR indicated the resident was administered the medication on the following dates and times when the resident's systolic blood pressure was below 120 or the resident's pulse was less than 60: -On 1/06/26 at 8:00 a.m., the resident was administered Carvedilol when the resident's systolic blood pressure was 109. -On 1/09/26 at 8:00 p.m., the resident was administered Carvedilol when the resident's systolic blood pressure was 112. -On 1/12/26 at 8:00 a.m., the resident was administered Carvedilol when the resident's systolic blood pressure was 110. -On 1/15/26 at 8:00 a.m., the resident was administered Carvedilol when the resident's pulse was 59. -On 1/17/26 at 8:00 a.m., the resident was administered Carvedilol when the resident's pulse was 56. -On 1/18/26 at 8:00 a.m., the resident was administered Carvedilol when the resident's pulse was 52. -On 1/19/26 at 8:00 a.m., the resident was administered			

	Carvedilol when the resident's systolic blood pressure was 107 and the resident's pulse was 56 -On 1/21/26 at 8:00 a.m., the resident was administered Carvedilol when the resident's systolic blood pressure was 112. -On 1/22/26 at 8:00 a.m., the resident was administered Carvedilol when the resident's systolic blood pressure was 114. Review of the February 2026 MAR indicated the resident was administered the medication on the following dates and times when the resident's systolic blood pressure was below 120 or the resident's pulse was less than 60: -On 2/10/26 at 8:00 a.m., the resident was administered Carvedilol when the resident's systolic blood pressure was 111. -On 2/12/26 at 8:00 a.m., the resident was administered Carvedilol when the resident's systolic blood pressure was 110 and the resident's pulse was 59. -On 2/13/26 at 8:00 a.m., the resident was administered Carvedilol when the resident's pulse was 58. -On 2/14/26 at 8:00 p.m., the			

	resident was administered Carvedilol when the resident's pulse was 57. -On 2/15/26 at 8:00 a.m., the resident was administered Carvedilol when the resident's pulse was 59. -On 2/15/26 at 8:00 p.m., the resident was administered Carvedilol when the resident's systolic blood pressure was 115. -On 2/17/26 at 8:00 a.m., the resident was administered Carvedilol when the resident's pulse was 56. -On 2/18/26 at 8:00 a.m., the resident was administered Carvedilol when the resident's systolic blood pressure was 116. -On 2/21/26 at 8:00 p.m., the resident was administered Carvedilol when the resident's pulse was 52. -On 2/23/26 at 8:00 a.m., the resident was administered Carvedilol when the resident's systolic blood pressure was 112. -On 2/28/26 at 8:00 p.m., the resident was administered Carvedilol when the resident's systolic blood pressure was 110.			

	During an interview on 2/4/26 at 9:15 a.m., Licensed Practical Nurse (LPN) 4 indicated if blood pressure parameters were in place for a medication, the medication should not be administered if the resident's blood pressure was out of parameters. On 3/4/26 at 12:45 p.m., the Executive Director provided a current copy of the document titled "Medication Administration" dated January 24. It included, but was not limited to, "Staff Member Administration Procedure...All medications shall be given...in accordance with the directions on the prescription or the physician's or other authorized prescriber's orders...." This Citation relates to Intake 467955			
R 0297	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1) (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana.	R 0297	**Corrective Action(s) for Residents Affected by the Deficient Practice** Residents E continues on pain medications without interruption. Resident E’s medication administration records were reviewed by nursing leadership on 3/13/26 and continues to receive medications timely.	03/27/2026

Based on interview and record review, the facility failed to ensure a resident's (Resident E) pain medication was available to administer for 1 of 3 residents reviewed for pharmacy services.

Findings include:

During an interview on 3/4/26 at 11:02 a.m., Resident E indicated in mid November last year (2025), the facility had run out of his pain medication. He did not receive his narcotic pain medication for a day and a half. The facility provided him with Tylenol, however, the Tylenol did not help at all with his pain.

The clinical record for Resident E was reviewed on 3/3/26 at 11:27 a.m. The resident's diagnoses included, but were not limited to, diabetes and pain.

The physician's order, with a start date of 12/6/24, indicated the resident was to receive Hydrocodone-Acetaminophen (narcotic pain medication) 10-325 mg (milligrams) four times a day for pain at 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m.

Review of the November 2025 medication administration record indicated the resident was not administered the

Corrective Action(s) for Other Residents Potentially Affected

Other residents have the potential to be affected by this deficient practice; however, none were affected. All residents receiving pain medications were reviewed to ensure medication is in stock at the community on 3/16/2026.

Measures to Ensure the Deficient Practice Does Not Recur

Wellness Director, Memory Care Director and Unit Coordinator will be educated by Regional Nurse on or before 3/16/2026 on pharmaceutical services including the responsibility of the community to ensure prescribed medications are available and observations are completed to document all attempts of resolving any interruptions. Wellness Director and/or designated nurse along with Guardian Pharmacist Consultants will educate nurses on or before 3/26/2026 on pharmaceutical services and nursing responsibilities in medication availability, documentation regarding medication availability as well as physician and pharmacy communications. Newly hired nurses will be educated during orientation ongoing. Wellness director and/or nurse designee

	narcotic pain medication on the following dates and times: -11/14/25 at 8:00 a.m., due to the resident's pain medication was unavailable, -11/14/25 at 12:00 p.m., due to the resident's pain medication was unavailable, -11/14/25 at 4:00 p.m., due to the resident's pain medication was unavailable, -11/14/25 at 8:00 p.m., due to the facility awaiting arrival from the pharmacy, -11/15/25 at 8:00 a.m., due to the resident's pain medication was unavailable and, -11/15/25 at 12:00 p.m., due to the resident's pain medication was unavailable. On 11/15/25 at 9:34 a.m., the November 2025 medication administration record indicated the resident received Tylenol, 650 mg due to complaints of pain all over with a rating of 10/10 with an outcome of no relief. The clinical record lacked documentation of staff attempts to re-order Resident E's pain medication until 11/15/25, after the resident had missed 5 doses of the pain medication.		will review the medical record and the dashboard to ensure medication availability as well as review of narcotic count sheets weekly for timely physician and pharmacy notification. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The Executive Director and/or designee will complete an audit reviewing MAR exceptions, Narcotic pain medication count sheets and observations noting any exceptions on the MAR for these medications for resident receiving Narcotic pain medication. Audit will be conducted for 5 residents per week for 4 weeks, then 3 residents per week for 4 weeks, then 1 resident per week for 4 weeks. The Executive Director will review results of the audits at the monthly QA meeting. The Quality Assurance committee will determine the need for further revisions or corrective actions as well as a need to change the frequency and length of continued audits.	

	During an interview, on 3/4/26 at 12:47 p.m., the Executive Director indicated the facility was responsible to ensure medications were available. During an interview, on 3/4/26 at 1:28 p.m., the Regional Nurse indicated they did not have a policy for pharmacy services. The facility followed the state regulations and the medication administration policy. On 3/4/26 at 12:45 p.m., the Executive Director provided a current copy of the document titled "Medication Administration" dated January 24. It included, but was not limited to, "Staff Member Administration Procedure...All medications shall be given...in accordance with the directions on the prescription or the physician's or other authorized prescriber's orders...." This Citation relates to Intake 467955			

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 SIGNATUREKathy Jones	TITLEExecutive Director	(X6) DATE03/16/2026