STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. Building B. Wing	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Capitol Nursing & Rehabilitation Center	2010 N Capitol Ave Indianapolis, IN 46202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a staff member did not initiate chest compressions to a hospice resident that had an advanced directive in place Do Not Resuscitate (DNR) code status. (Resident B)Findings include:The clinical record for Resident B was reviewed on [DATE] at 9:45 a.m. The diagnosis included, but was not limited to: Alzheimer's disease. An Indiana Physician Orders Scope of Treatment (POST), dated [DATE], indicated Resident B had a Do Not Resuscitate (DNR) advanced directive. A care plan, dated [DATE], indicated Resident B had an advanced directive in place, DNR. A care plan, dated [DATE], indicated Resident B has difficulty making self understood not able to communicate. A care plan, dated [DATE], indicated Resident B received hospice services related to Alzheimer's disease. A physician's order, dated [DATE], indicated Resident B's code status was DNR. An event, dated [DATE], indicated Resident B had an unwitnessed fall. The resident was found having seizure activity with a laceration to the back of her head. She was sent to the emergency room (ER) for evaluation. A nursing progress note for Resident B, dated [DATE] at 7:34 a.m., indicated Called to unit from can [Certified Nursing Assistant] .resident had a fall .noted resident on floor near dining room having a seizure with blood noted coming from the back of her head .resident continues in seizure with snoring sounds and respirations at 10 resident seizure lasted 4 minutes, ems [Emergency Medical Services] and fire department arrived. Resident transported to [hospital] ER [medical provider] notified .Resident vs [vital signs] 159/81[blood pressure] 109 [heart rate] 24 [respirations]. A nursing progress note for Resident B, dated [DATE] at 10:30 p.m., indicated Resident returned from ER visit at 930pm. No new orders received,.Area to back of head intact without any s/s [signs/symptoms] of bleeding noted. resident shows no s/s of headache, pain or discomfort noted at this time. resident resting in her room at this time. staff will continue to monitor resident. An observation was made of Resident B on [DATE] at 10:29 a.m. The resident was observed in bed with eyes closed. The television was on in the resident's room. An observation was made of Resident B on [DATE] at 2:23 p.m. The resident was observed sitting on the side of the bed. The resident was clothed and the television was on. An interview was conducted with Hospice Staff Nurse 1 on [DATE] at 10:38 a.m. She indicated she was notified Resident B had fallen and started to shake. The facility nurse thought the resident was seizing and provided Cardiopulmonary Resuscitation (CPR) to the resident when she had a heartbeat and had not stopped breathing. Resident B's Representative was very upset about the facility staff initiating CPR. The facility staff had informed Hospice Staff Nurse 1, they would not call hospice prior to sending a resident out to the hospital that had fallen and was bleeding from a head wound. An interview was conducted with the Assistant Director of Nursing Services (ADNS) on [DATE] at 11:26 a.m. She indicated on the morning of [DATE], she called to the memory care unit due to Resident B had fallen. After entering the unit, she had observed the resident on the floor bleeding from the back of her head. License Practical Nurse (LPN) 2 was on the floor and on her cell phone with a 911 dispatcher. At that time, Resident B was seizing and snoring breath sounds. LPN 2 was pushing on the resident's chest area, but she was trying to rouse the resident. She had suggested to turn the resident on her side, but they decided not to move her due to not knowing the extent of the resident's injuries to her head. EMS arrived and transferred the resident to the hospital emergency room. After, she notified Resident B's Representative and hospice personnel. An interview was conducted with LPN 2 on [DATE] at 11:41 a.m. She indicated she was notified Resident B had fallen. She ran into the memory care unit and checked Resident B's code status. She observed the resident on floor and having a seizure. The resident's back of head was bleeding a lot and her breathing sounded like a snore. She contacted 911 and was instructed by the dispatcher to initiate CPR. LPN 2 performed light chest compressions to the resident. The resident came out of the seizure and breathing returned to normal. She then turned the resident on her side. EMS arrived and wrapped the resident's head, placed a neck brace on and oxygen. The resident was awake and breathing normal when she was transferred to the hospital. The resident was returned later that day. During the incident, she was in the heat of the moment. It was the first time she had experienced a resident in that condition. ADNS had handled the paperwork and notified the medical provider, family and hospice. Education was provide to her after the incident. She was educated about moving in correct order which means understand the situation and code status. An interview was conducted with Qualified Medication Aide (QMA) 3 on [DATE] at 12:25 p.m. She indicated on the morning of [DATE], she had walked on the memory care unit and had observed Resident B on the floor with nursing