| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155226 | A. Building<br>B. Wing | 07/30/2025 |

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| North Capitol Nursing & Rehabilitation Center | 2010 N Capitol Ave<br>Indianapolis, IN 46202 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>Based on observation, interview, and record review, the facility failed to perform hand hygiene during medication administration and failed to ensure that indwelling catheter tubing and drainage bag were kept off a fall mat and the floor for 6 of 8 residents reviewed for medication administration and 1 of 1 resident reviewed for urinary catheter. (Residents' 5, 12, 26, 34, 40, 50, and 72) Findings include:<br><br>1a. The clinical record for Resident 26 was reviewed on 7/24/25 at 9:30 a.m. The diagnoses included, but were not limited to, paranoid schizophrenia.<br><br>An observation was conducted of a medication administration for Resident 26 with Licensed Practical Nurse (LPN) 2 on 7/29/25 at 8:31 a.m. LPN 2 was observed obtaining the resident's blood pressure by utilizing a Dinamap (an electronic device for blood pressure monitoring). She then went to the medication cart and prepped for the resident's medication for administration. During that time, she was observed touching her hair, eye glasses, the computer mouse, keys, medication cards, medication cups, water pitcher and drinking cups. After, she returned back to the resident and administered the medications in the medication cup. There was no observation of LPN 2 utilizing hand hygiene before or after the medication administration to the resident.<br><br>1b. The clinical record for Resident 50 was reviewed on 7/24/25 at 9:45 a.m. The diagnoses included, but was not limited to, stroke.<br><br>An observation was conducted of a medication administration for Resident 50 with LPN 2 on 7/29/25 at 8:42 a.m. LPN 2 was observed at the medication cart preparing the resident's medications. She had pulled the medication cards out of the medication cart and popped the pill medications in the medication cup. During the preparation, LPN 2 had a black hair tie on her right wrist with long black strands of hair hanging from the hair tie. She was observed touching her hair, the computer mouse, keys, medication cards, medication cups, water pitcher and drinking cups. After, she knocked onto the resident's door and administered the medications to the resident. There was no observation of LPN 2 utilizing hand hygiene before the medication administration.<br><br>1c. The clinical record for Resident 40 was reviewed on 7/24/25 at 10:45 a.m. The diagnoses included, but was not limited to, stroke.<br><br>An observation was conducted of a medication administration with LPN 2 for Resident 40 on 7/29/25 at 8:50 a.m. LPN 2 was observed obtaining the resident's blood pressure utilizing a hand held blood pressure monitoring device. She then went to the medication cart and pulled the resident's medications. LPN 2 pulled the medication cards and popped the pill medications into a medication cup. During that time, she touched the computer mouse, medication cards, medication cups, water pitcher and drinking cups. After, LPN 2 went into the resident's room and administered the medication to the resident. There was no observation of LPN 2 utilizing hand hygiene prior to the administration of<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | medications to the resident.<br><br>1d. The clinical record for Resident 12 was reviewed on 7/24/25 at 11:45 a.m. The diagnoses included, but was not limited to, Parkinson's disease.<br><br>An observation was conducted of a medication administration with LPN 2 for Resident 12 on 7/29/25 at 9:08 a.m. LPN 2 was observed preparing the resident's medications at the medication cart. She pulled the medications, removed a pair of gloves from a box, and then poured water from the water pitcher into a cup. After, she entered the resident's room, donned on her gloves. She then touched the bedside table with her gloved hands. She then administered the resident's nasal spray. After, she doffed the gloves and administered the pill medications. During that time, the resident had requested removing her straw from her Styrofoam cup and place the straw into her new cup. LPN 2 was observed donning on one glove; removing the straw and placing it in the new cup. After, she doffed her glove and left the resident's room. There was no observation of LPN 2 utilizing hand hygiene before or after donning gloves nor prior to administration of medications to the resident.<br><br>1e. The clinical record for Resident 34 was reviewed on 7/24/25 at 1:00 p.m. The diagnoses included, but was not limited to, hypertension.<br><br>During an observation of a medication administration with LPN 2 for Resident 34 on 7/29/25 at 9:24 a.m., LPN 2 was observed preparing the resident's medication from the medication cart. First, the resident's blood pressure was obtained by utilizing a Dinamap. She then pulled the resident's medications from the medication cart. After, she crushed the medications. During that time, LPN 2 was observed touching the medication cards, keys, Ensure supplement, pill crusher, plastic sleeves, medication cups and drinking cups. She then administered the medication to the resident. There was no observation of LPN 2 utilizing hand hygiene prior to the medication administration to the resident.<br><br>An interview was conducted with the Director of Nursing (DON) on 7/29/25 at 3:02 p.m. She indicated LPN 2 should have utilized hand hygiene prior to administration of the medications to the residents.<br><br>2. The clinical record for Resident 72 was reviewed on 7/29/25 at 11:00 a.m. The diagnoses included, but were not limited to, gastrostomy tube.<br><br>An observation of medication administration was conducted, on 7/29/25 at 11:15 a.m., with Registered Nurse (RN) 3. RN 3 performed hand hygiene prior to arriving at the medication cart, she then used a laptop on the medication cart to view and verify the resident's orders. RN 3 prepared Resident 72's medication by crushing one tablet and placed it into a medication cup, and poured 10 milliliters of a liquid sucralfate into another medication cup. RN 3 then entered Resident 72's room and donned personal protective equipment (PPE), a gown and gloves. Hand hygiene was not performed prior to donning PPE. RN 3 verified placement of the gastrostomy tube before administering the resident's medications. RN 3 then doffed her PPE and performed hand hygiene before leaving the resident's room.<br><br>During an interview with RN 3 on 7/29/25 at 11:35 a.m., she indicated she normally used hand hygiene before donning PPE and administering medication, but must have forgotten during the observation.<br><br>3. The clinical record for Resident 5 was reviewed on 7/25/25 at 10:17 a.m. The diagnoses included, but were not limited to, epilepsy and gastrostomy (g-tube) status.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A care plan, last reviewed 7/9/25, indicated Resident 5 required an indwelling urinary catheter related to neurogenic bladder. The goal was for her to be free from complications related to the indwelling catheter. The interventions included, but were not limited to, do not allow catheter tubing or any part of the drainage system to touch the floor and to position drainage bag below the bladder.<br><br>During an observation on 7/25/25 at 10:08 a.m., Resident 5 was observed lying in bed in her room. The urinary catheter tubing was laying on a fall mat at her bedside. The urine in the tubing was dark yellow in color.<br><br>During an observation on 7/28/25 at 1:51 p.m., Resident 5 was observed lying in her bed. The bed was in the low position. The catheter tubing was laying on the fall mat beside her bed and the urinary drainage bag was laying behind the fall mat, touching the floor.<br><br>During an interview on 7/28/25 at 1:52 p.m., RN 3 indicated the catheter tubing should not be laying on the fall mat and the urinary drainage bag should not be touching the floor.<br><br>A Standard and Transmission-Based Precautions (Isolation) Policy, last revised 2/2025, was provided by the Executive Director on 7/30/25 at 3:40 p.m. It indicated .Hand Hygiene . Perform hand hygiene: Before and after having direct contact with a resident . Use of Personal Protective Equipment - Gown and Gloves: Applies to anyone entering the room who may touch the resident or objects in the room should wear PPE. Perform Hand Hygiene prior to entering the room and before leaving the room .Gloves: Perform hand hygiene prior to donning and after doffing gloves .<br><br>An Infection Control Prevention and Control Program policy was provided by the DON on 7/29/25 at 3:07 p.m. It indicated, .Prevention of spread of infections is accomplished by the core principles of infection control including, but not limited to hand hygiene.<br><br>3.1-18(b)(1)<br><br>3.1-18(l) |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>Based on observation and interview, the facility failed to ensure a call light system and ceilings and walls in residents' rooms were in good repair for 7 of 7 residents reviewed for environment, and to provide a home-like environment in the memory care unit common area with the potential to effect 19 of 19 residents. (Residents 1, 2, 15, 31, 34, 35, and E)Findings include: 1. On 7/24/25 at 11:02 a.m., the walls in Resident E's room were observed to have scrapes with paint missing, as well as chipping in the baseboards. 2. On 7/24/25 at 11:32 a.m. a random observation was conducted of exposed wiring from a call light cord coming out of the wall in Resident 31's room.3. On 7/24/25 at 1:36 p.m. an observation was conducted of gouges in the walls and baseboards of Resident 35's room. During this observation, Resident 35 indicated the walls had been like that for a year and he would like it to be fixed. 4. On 7/24/25 at 1:42 p.m. a random observation was conducted of gouges on a wall and a missing baseboard in Resident 34's room.5. On 7/25/25 at 10:27 a.m., the walls in Resident 2's room were observed to have gouges and missing baseboards. 6. On 7/28/25 at 10:52 a.m., a wall in Resident 15's room was observed to have gouges and cracks adjacent to the window. Splatter of unknown origin were also observed on the ceiling. 7. On 7/28/25 at 10:56 a.m., a random observation revealed splatter from an unknown origin on the ceiling in Resident 1's room as well as a hole in the wall adjacent to the window.An environmental tour of the facility was conducted, on 7/28/25 at 2:00 p.m., with the Executive Director (ED) and the Maintenance Director. Observations of Resident E and Resident 35's room revealed gouges and missing paint towards the bottoms of the wall just above the baseboards. The baseboards were also noted to have missing, broken off pieces. The Maintenance Director indicated the damage occurred from the residents' wheelchairs and that the wall had been previously repaired. The ED indicated it was more cost effective to paint and repair the walls instead of placing a barrier to prevent damage to the walls Resident 1 and 15's rooms were observed with splatter on the ceiling and gouges in the walls. The ED indicated facility staff from various departments conduct companion rounds during which the environment can be observed to address potential issues. He indicated these issues must have been missed during those rounds. Resident 31's room was observed alongside the ED and Maintenance Director, revealing the exposed wiring from the resident's call light with the cover detached from the wall. The ED indicated it was common for the coverings to come off of the wall and they have to reapply adhesive to reattach it. The memory care unit common area on the third floor was observed to have multiple tables pushed to the center of the room and plain walls with no decorations or personalization. The ED indicated the common area did appear plain and could use more personalization to provide a more home-like environment. On 7/30/25 at 3:00 p.m., the ED indicated the facility did not have a policy related to home-like environment standards.3.1-19(f)(5) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>Based on interview and record review, the facility failed to timely coordinate care with hospice for scheduled pain medication and failed to administer medication as ordered for 1 of 1 resident reviewed for hospice and 1 of 5 residents reviewed for unnecessary medications. (Resident 11 and Resident D) Findings include: 1. The clinical record for Resident 11 was reviewed on 7/23/25 at 2:14 p.m. The diagnoses included, but were not limited to, senile degeneration of the brain and generalized arthritis.<br><br>A care plan, initiated 4/8/25, indicated Resident 11 required hospice services related to his diagnosis of senile degeneration of the brain. The goal was for him to experience death with dignity and physical comfort. The interventions included, but were not limited to, administer pain medications as ordered and notify physician and hospice of unrelieved or worsening pain and for the hospice licensed nurse to visit two times weekly to obtain vital signs and provide medication management.<br><br>A Hospice Interdisciplinary Group (IDG) Comprehensive Assessment and Plan of Care Update Report, dated 5/22/25, indicated Resident 11 was to have tramadol (pain medication) 25 milligram (mg) twice daily for pain.<br><br>The Electronic Health Record (E.H.R.) for Resident 11 did not contain a physician's order for tramadol 25 mg to be administered twice daily for pain.<br><br>A Quarterly Minimum Data Set (MDS) assessment, completed 7/7/25, indicated Resident 11 had short-term and long-term memory problems.<br><br>During an interview on 7/30/25 at 12:21 p.m., Hospice Nurse (HN) 4 indicated she had given the order to start tramadol 25 mg twice daily on 5/22/25. She could not recall which of the facility nurses she had given the order to. She had intended for Resident 11 to receive tramadol 25 mg twice daily for pain and was unaware that he had not been receiving the medication twice daily.<br><br>During an interview on 7/30/25 at 2:21 p.m., the Director of Nursing (DON) indicated the facility did not have an order for Resident 11 to receive tramadol 25 mg twice daily. She was unsure why the order had not been placed in the electronic health record.<br><br>During an interview on 7/30/25 at 4:38 p.m., the Nurse Consultant (NC) indicated the HN should ask for a copy of the current electronic medication administration record (EMAR) when they were visiting the hospice resident and reconcile the EMAR with their orders to ensure the facility, and the hospice company had coordinated care.<br><br>2. The clinical record for Resident D was reviewed on 7/24/25 at 10:45 a.m. The diagnoses included, but were not limited to, stroke.<br><br>A physician's order, dated 3/4/22, indicated the resident was to receive 100 milligrams of metoprolol once a day.<br><br>The July 2025 Medication Administration Record (MAR) indicated the following days the 100 milligrams of metoprolol was not administered as ordered:<br><br>7/13/25 – documented as not administered due to low blood pressure; blood pressure reading was 108/74,<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 7/14/25 – no documentation why the medication was not administered,<br><br>7/16/25 – no documentation why the medication was not administered, and<br><br>7/25/25 – documented as not administered due to low blood pressure; blood pressure reading was 94/68.<br><br>Resident D's medical record did not indicate the medical provider was notified to hold and/or not administer the 100 milligrams of metoprolol.<br><br>An interview was conducted with the Director of Nursing on 7/29/25 at 3:02 p.m. She indicated Resident D's 100 milligrams of metoprolol order should have had parameters when the medication should be held and the order did not. The staff should have called the provider to receive an order to hold the medication.<br><br>On 7/30/25 at 4:14 p.m., the DON provided the Hospice Policy, last reviewed September 2024, which indicated .It is the policy of this facility that when a resident elects the hospice benefit, the contracted hospice company and the facility will coordinate to establish both a person centered plan of care reflecting the physical, spiritual, mental and psychosocial needs of the resident as well as a pattern of communication between the hospice company, healthcare professionals, facility staff and resident/ representative.<br><br>3.1-37(a) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>Based on observation, interview, and record review, the facility failed to administer gastric tube feeding as ordered by the physician for 1 of 1 resident reviewed for gastric tube feeding (Resident 5). Findings include: The clinical record for Resident 5 was reviewed on 7/25/25 at 10:17 a.m. The diagnoses included, but were not limited to, epilepsy and gastrostomy (g-tube) status. A physician's order, dated 4/21/25, indicated she was to receive Glucerna 1.5 (type of nutritional formula) at 50 milliliters (mLs) an hour with 45 mLs of water flushes per hour. A care plan, last edited 7/3/25, indicated Resident 5 was at nutritional risk related to dependency on enteral nutrition (nutrition via gastric tube) for nutritional needs. The goal was for her to maintain her weight without significant weight changes. The interventions included, but were not limited to, provided enteral feedings as ordered by the physician. On 7/25/25 at 10:17 a.m., Resident 5 was observed lying in her bed. Her gastric tube (g-tube) feeding pump was running at 55 mLs per hour. On 7/28/25 at 2:37 p.m., Resident 5 was observed with Registered Nurse (RN) 3. Resident 5 was lying in her bed with her g-tube feeding running. RN 3 indicated the feeding was running at 55 mLs an hour with 40 mLs of water flushes each hour. RN 3 checked the physician's orders and indicated the g-tube feeding should be running at 50 mLs an hour and the water flushes should be 45 mLs per hour. RN 3 would adjust the rate to reflect the physician's order. On 7/29/25 at 9:46 a.m., the Executive Director provided the Enteral Therapy Policy, last reviewed January 2016, which indicated .A licensed nurse will take, note, and implement physician orders for enteral therapy. 3.1-44(a)(2) |

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| F 0744<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.<br><br>Based on observation, interview, and record review, the facility failed to provide adequate supervision for a resident with intrusive wandering, document new behavior events in the clinical record, and timely update the plan of care with new interventions for behaviors for 2 of 3 residents reviewed for dementia care (Resident K and Resident 61). Findings include: 1a. The clinical record for Resident K was reviewed on 7/23/25 at 11:15 a.m. The diagnoses included, but were not limited to, dementia with behavioral disturbances, anxiety, and traumatic brain injury. He was readmitted to the facility, on 7/16/25, following an extended hospital stay. A Quarterly Minimum Data Set (MDS) assessment, completed 6/6/25, indicated he rarely/never made himself understood and sometimes understood what was said to him. He had short-term and long-term memory problems and severely impaired decision-making skills. He had displayed inattention. He displayed physical behaviors, such as hitting, kicking, scratching or pushing one to three times in the seven day look back period. He had displayed wandering behaviors daily in the seven day look back period. He was able to walk 150 feet with supervision. A care plan, last reviewed on 7/16/25, indicated Resident K would wander into rooms on the secured unit. The goal was for him to not experience lasting distress, to not cause distress to others, and to not cause harm to himself or others. The interventions included, but were not limited to, address any immediate needs such as hunger, thirst, pain, boredom, loneliness, or tiredness, encourage him to engage in activities, ensure his safety, when redirecting the resident to call him by name and then approach, provide a calm, unhurried, and supportive approach, and remove him from the immediate area to further evaluate needs. 1b. The clinical record for Resident 61 was reviewed on 7/23/25 at 11:10 a.m. The diagnoses included, but were not limited to, dementia with psychotic disturbance. A Quarterly MDS assessment, completed 5/16/25, indicated she had short-term and long- term memory problems and was able to recall the location of her own room. She had experienced delusions. She could walk 150 feet independently. A care plan, with a start date of 1/16/25 and last revised 7/30/25, indicated she had an altercation with a peer. The goal was for her not to have distress related to the incident. The interventions included, but were not limited to, separate resident for safety and observe for signs and symptoms of distress, initiated on 1/16/25.On 7/23/25 at 11:15 a.m., Resident K was observed attempting to walk into Resident 61's room and was redirected by the Memory Care Coordinator (MCC). Resident K's clinical record contained a Nursing Progress Note, dated 7/26/25 at 6:00 a.m., that indicated a nursing assistant reported Resident K was bleeding. The nurse saw a scratch on Resident K's arm and wiped the scratch with normal saline.An Incident Report submitted to the Indiana Department of Health, dated 7/26/25 at 5:01 a.m., was provided by the Executive Director (ED) on 7/28/25 at 10:45 a.m. The Incident Report indicated that Resident K and Resident 61 had a resident-to-resident incident. The type of injury was a small scratch on Resident K's hand. The immediate action taken was both residents were separated, and the families and physicians were notified.The clinical record for Resident K did not include a Behavior Communication Note or documentation about the reportable incident between Resident K and Resident 61. Resident K's clinical record contained a Nursing Progress Note, dated 7/26/25 at 11:31 a.m., that indicated Resident K had been pacing up and down the hallway going from room to room. Resident K was redirected multiple times and unable to be redirected. Resident K was following other residents down the halls. Resident K was administered lorazepam (anti-anxiety medication) for restlessness and some agitation. Resident K's clinical record contained a Nursing Progress Note, dated 7/27/25 at 9:51 a.m., that indicated Resident K had wandered into another resident's room. The resident had pushed Resident K out of his room. There were no injuries noted and no signs or symptoms of pain or discomfort. Resident K was placed on 15-minute checks. The Executive Director, Director of Nursing Services, Assistant Director of Nursing Services, Nurse Practitioner and Resident K's wife were made aware. Resident K's clinical record contained a Nursing Progress Note, dated 7/28/25 at 3:09 a.m., (continued on next page) |

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| F 0744<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | indicated there were no apparent injuries from the earlier incident. Resident K remained on 15-minute checks. Resident K was ambulating with steady gait quickly in the hallway and attempting to wander in and out of rooms. Redirection was offered to Resident K using a kind soft voice, food, toileting, and support. As needed lorazepam was administered due to Resident K becoming aggravated when redirection was attempted. A progress note, dated 7/28/25 at 8:41 a.m., indicated Resident K had been involved in two separate altercations over the weekend related to wandering in and out of other residents' rooms. Resident K resided in the cottage (dementia care) unit and often wandered without purpose. Resident K was placed on 15-minute checks related to other residents becoming agitated with resident K's wandering. It was reported that Resident 61 had scratched Resident K during their altercation, but upon further assessment the scratches were noted to be in healing stage. One of the scabs on the scratches became dislodged following the altercation. Resident K does not remember either incident when questioned. Resident K's clinical record did not contain an Interdisciplinary Team (IDT) review of the incident, on 7/26/25, or the intrusive wandering. A care plan, initiated 7/28/25, indicated Resident K had an episode of intrusive wandering. The goal was for the staff to redirect him during increased wandering. The approach was for increased supervision, offer snacks, walk with resident, and redirect resident back to his room. Resident 61's clinical record did not contain documentation of the incident between Resident 61 and Resident K, a New Behavior Event, or a Behavior Communication Note of the incident between Resident 61 and Resident K on 7/26/25. Resident 61's care plan had not been updated. Resident K's clinical record contained the following progress notes: A Memory Care Social Services Progress Note, dated 7/28/25 at 4:19 p.m., indicated Resident K had displayed the behavior of intrusive wandering. The immediate interventions done were to walk with Resident K, offer snacks, and redirect him back to his room. A Nursing Progress Note, dated 7/28/25 at 10:10 p.m., indicated Resident K continued on 15- minute checks. Resident K was continuously wandering from room to room and up and down the hall. When redirection was attempted multiple times, Resident K would walk faster. He was redirected to his room unsuccessfully and continued to wander. As needed medication was given. A Nursing Progress Note, dated 7/29/25 at 2:26 a.m., indicated Resident K remained on 15-minute checks. He was pacing up and down the hallway in a quick manner, opening closed doors, and entering rooms. Staff immediately redirected him. Resident K was unaware of personal space nor intrusive behavior. Toileting was offered and as needed pain medication was given due to him rubbing his knee and back. He consumed a snack and fluid before returning to his room. A Memory Care Social Services Progress Note, dated 7/29/25 at 1:39 p.m., indicated Resident K was up for breakfast and lunch in the dining room with staff walking up and down the hallway with him. He remained on 15-minute checks. He was resting in bed at that time with no signs or symptoms of distress.During an interview on 7/29/25 at 2:30 p.m., the Memory Care Coordinator (MCC) and Activity Aide (AA) 5 indicated that Resident 61 was not normally aggressive with other residents. Resident 61 normally told other residents to go on if they came into her room. Resident K had always wandered into other residents rooms and this was not a new behavior for him. The staff redirected him with snacks or by walking with him.Resident K's clinical record included a Nursing Progress Note, dated 7/30/25 at 5:17 a.m., that indicated Resident K was ambulating and following Resident 61 up the hallway. Resident 61 turned around and shoved Resident K, causing him to fall against elevator wall and slide down to his coccyx (bottom). Resident K did not hit his head and there were no apparent injuries. Resident 61's clinical record contained a Nursing Progress Note, dated 7/30/25 at 5:22 a.m., that indicated Resident 61 had been ambulating and was being followed by Resident K. Resident 61 began screaming and yelling for Resident K to quit following them. Resident 61 then turned around and shoved Resident K, causing him to fall against the elevator wall and slide down to his coccyx (bottom). Resident 61 then went to her room and slammed the door. Resident K's clinical record contained a Nursing Progress Note, dated 7/30/25 at 5:26 a.m., that indicated Resident K continued to attempt to enter other rooms and follow people closely while walking in the hallway. During an interview on 7/30/25 at 9:21 a.m., the Director of Nursing (DON) (continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155226 | A. Building<br>B. Wing | 07/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| North Capitol Nursing & Rehabilitation Center | 2010 N Capitol Ave<br>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.

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| F 0744<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | indicated Resident K had one-on-one care started after the incident. Resident K had been on 15-minute checks up until the time of the incident. Resident behaviors were documented in the nursing notes. During an interview on 7/30/25 at 2:22 p.m., the DON indicated the incident, on 7/26/25 at 5:00 a.m., between Resident K and Resident 61 had not been witnessed. The Certified Nurse Aide (CNA) had found Resident K and Resident 61 standing close together with Resident K's hand bleeding. The CNA was unable to definitively say Resident 61 scratched Resident K. Resident K had 15-minute checks initiated on 7/26/25. The memory care unit was staffed with one CNA on the night shift and the Nurse of the attached ventilator unit covered the dementia unit as well. On 7/29/25 at 3:34 p.m., the Executive Director provided the Behavior Management Policy, last revised August 2022, which indicated .It is the policy of American Senior Communities to provide behavior interventions for residents with problematic or distressing behaviors . Interventions provided by both individualized and non pharmacological and part of a supportive physical and psychosocial environment that is directed toward preventing, relieving and/or accommodating a resident's behavioral expression.1. Care plans should be initiated for any behavioral expression that is problematic or distressing to the resident, other resident or caregivers. Care plan interventions should be individualized and non pharmacological interventions which address both proactive and responsive interventions.4. If the behavioral expression is new, worsening, or high risk the nurse will record the behavior using the New/Worsening Behavior Event. New or worsening behaviors are reviewed by the IDT for assessment and preventative actions. New/Worsening Behaviors include: a. Behaviors that are new for the resident b. Behaviors that are directed at another resident.c. Behaviors that are increasing in either frequency or severity d. Behaviors that have potential for risk to others including sexual advances, intrusive wandering.The IDT review is a discussion with the team as to the behavioral expression, and evaluation of interventions, presentation of new interventions if applicable, and an assessment of any underlying causes of the behavior [i.e. pain, environmental stressor, medical illnesses, etc.]. The root cause and preventative interventions will be included in the resident's plan of care. 5. If the behavioral expression is not new, worsening or high risk; the nurse will record the behavior in the progress notes using the Behavior Communication Note. The IDT will review progress notes the next business day to determine if immediate follow up action is required for the Behavior Communication. If the behavior requires an interdisciplinary response as described above, the IDT will complete the IDT Behavior Review. If not, the plan of care will be reviewed and updated in needed to include a description of the behavior and effective interventions.3.1-37(a) |