STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155816	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arlington Place Health Campus	1635 N Arlington Ave Indianapolis, IN 46218

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to timely complete self-medication assessments for a resident who had medication at bedside and a resident that self administered her insulin medications 2 of 3 residents medication administration. (Resident F and Resident D) Findings include: 1. The clinical record for Resident F was reviewed on 5/28/26 at 11:00 a.m. The resident's diagnosis included, but was not limited to, depression (serious mood disorder). A Quarterly Minimum Data Set (MDS) Assessment, completed 5/7/26, indicated the resident was moderately cognitively impaired. A care plan, last reviewed 5/20/26, indicated Resident F presented with a diagnosis of depression. The goal was for the resident to remain free of the symptoms of depression. The interventions included to administer medications as ordered by the physician. On 5/28/26 at 11:58 a.m., Resident F was observed in his room, sitting in his bed. The bedside table was next to the bed. A medication cup containing 4 pills was observed on the bedside table. Resident F indicated the nurse had left the medication for him to take. Resident F did not know what the medications were. During an interview on 5/28/26 at 12:00 p.m., Licensed Practical Nurse (LPN) 5 indicated the medication cup contained Resident F's morning medications. LPN 5 was unsure if Resident F had a self-medication assessment completed. During an interview on 5/28/26 at 3:30 p.m., the Director of Nursing Services (DNS) indicated Resident F did not have a self-medication assessment completed in his clinical record. 2. The clinical record for Resident D was reviewed on 5/28/26 at 9:40 a.m. The diagnoses included but were not limited to: diabetes mellitus (ineffectively utilizes the insulin made in the body either can not produce enough insulin or does not use the insulin the body makes) A physician order, dated 3/16/26, indicated Resident D was to receive a sliding scale of fast-acting lispro insulin. The sliding scale was the following: blood sugar reading of 151 – 200 = 2 units of insulin, blood sugar reading of 201 – 250 = 4 units of insulin, blood sugar reading of 251 – 300 = 6 units of insulin, (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blood sugar reading of 301 – 350 = 8 units of insulin, blood sugar reading of 351 – 400 = 10 units of insulin, blood sugar reading greater than 400 call the medical provider A physician order, dated 3/16/26, indicated Resident D was to receive 20 units of fast-acting lispro insulin three times a day. The staff was to hold the lispro if blood sugar was less than 110. A physician order, dated 3/16/26, indicated Resident D was to receive 40 units of long-acting lantus insulin with breakfast. The May 2026 Medication/Treatment Administration Record (MAR/TAR) indicated the resident had self- administered her insulin medications on 5/2/26, 5/8/26, 5/14/26, and 5/19/26. The resident's clinical record did not include a self-medication assessment that was conducted, medical provider orders, or a care plan developed indicating resident was able to self-medicate her insulin medications. An interview was conducted with the Director of Nursing Services (DNS) on 5/29/26 at 10:45 a.m. She indicated Resident D chose the dosage amount and self-administered her insulin medications. The medical provider was aware. The staff did not conduct a self-medication assessment for Resident D. A Guidelines for Self-Medication of Medications policy was provided by the DNS 5/28/26 at 3:41 p.m. It indicated, Purpose Statement. The purpose of this policy is to: To ensure the safe administration of medication for residents who request to self- medicate or when self- medication is a part of their plan of care. Policy Guidelines for Self Administering of medications. Residents requesting to self-medicate or has self-medication as a part of their plan of care shall be assessed using the observation Trilogy- Self Administration of Medication within the electronic health record. Results of the assessment will be presented to the physician for evaluation and an order for self-medication. The order should include the type of medication(s) the resident is able to self- medicate.e.: all oral meds, oral meds with the exception of., nebulizer treatment only, all medications including injection, oral, inhalers, drops, etc.6. A Self-Medication plan of care will be initiated and updated as indicated. 7. The Assessment will be reviewed quarterly, and PRN with change of condition. 8. The assessment will be documented in the EHR. This citation is related to 3002975. 410 IAC (Indiana Administrative Code) 16.3.1-11

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility failed to ensure food temperatures were at an appetizing temperature and kept at safe holding temperatures. This had the potential to affect 70 of 70 residents that eat the food prepared and served from the kitchen.Findings include:An interview was conducted with Resident D on 5/28/26 at 10:29 a.m. She indicated breakfast, lunch and dinner meals were always served cold.An observation was made of the main kitchen with the DM 11 on 5/28/26 at 12:26 p.m., Dietary Manager (DM) 11 utilizing a thermometer had taken the food temperatures of the prepared food to be served. The smoked sausage had tempted 123 degrees Fahrenheit. DM 11 indicated the smoked sausage needed to be reheated. He preferred all food to be held at 150 degrees Fahrenheit, but the regulation stated food temperatures were to be held at 135 degrees Fahrenheit.During a dining observation on 5/28/26 at 11:57 a.m., Residents' N, O, P were sitting in the dining room waiting for the lunch meal. They indicated the food that was supposed to be hot, was served cold at every meal in the dining room.An interview was conducted with Resident M on 5/28/26 at 12:38 p.m. She indicated resident council discussed food temperature concerns at every meeting. The food that was suppose to be hot, was normally served cold.A hot and cold holding policy was provided by the Director of Nursing Services (DNS) on 5/28/26 at 3:41 p.m. It indicated, Purpose. The purpose of this policy is to: Give guidelines to holding temperatures.Procedure.Hot food in the steam table should be at least 135 or higher degrees Fahrenheit and arrive approximately at greater than or equal to 120 degrees Fahrenheit when the resident is served.This citation is related to Intake 3002975. 410 IAC (Indiana Administrative Code) 16.2-3.1-21(a)(2)