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	12/08/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to ensure the resident representative for a cognitively impaired resident was informed in advance of the risks and benefits of medications for 1 of 5 residents reviewed for informed consent. (Resident 3)Findings include:The clinical record for Resident 3 was reviewed on 12/4/25 at 10:27 a.m. The diagnoses included, but were not limited to, dementia, chronic kidney disease, and severe protein-calorie malnutrition.A Minimum Data Set (MDS) assessment, dated 10/10/25, indicated the resident was severely impaired cognitively.A physician's order, dated 10/4/25 and discontinued 10/8/25, indicated to administer olanzapine (an antipsychotic medication) 2.5 milligrams twice per day.A physician's order, dated 10/7/25, indicated to administer Trazodone (an antidepressant medication which could be used as an off-label treatment for insomnia) 25 milligrams at bedtime for insomnia.A facility psychotropic medication informed consent observation, dated 10/8/25, indicated Resident 3 was educated on the risks, benefits, alternative treatment options, and any applicable black box warnings.During an interview, on 12/4/25 at 12:23 p.m., CNA 8 indicated Resident 3 was confused. She would not be able to understand the side effects of medications.During an interview, on 12/4/25 at 12:24 p.m., Licensed Practical Nurse (LPN) 7 indicated Resident 3 could not understand the side effects of her medications. She was confused.During an interview, on 12/5/25 at 11:25 a.m., the Director of Nursing (DON) indicated Resident 3 had impaired cognition and staff would need to educate the family to obtain informed consent.During an interview, on 12/8/25 at 9:48 a.m., Clinical Support Nurse 1 indicated staff should educate families to obtain informed consent for residents with a low cognitive status.A current facility policy, titled Psychotropic medication use and gradual dose reduction guidelines, dated as last revised 3/10/25 and received from Clinical Support Nurse 1 on 12/8/25 at 10:00 a.m., indicated .A consent shall be obtained upon admission for ordered psychotropic medications to ensure appropriate indications for use and that the Resident/Responsible party is educated on the risks, benefits, alternative treatment options and applicable black box warnings.3.1-3(n)(2)

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to ensure the resident representative for a cognitively impaired resident was notified of a significant weight loss for 1 of 3 residents reviewed for notification of change. (Resident 3)Findings include:The clinical record for Resident 3 was reviewed on 12/4/25 at 10:27 a.m. The diagnoses included, but were not limited to, dementia, chronic kidney disease, and severe protein-calorie malnutrition.A Minimum Data Set (MDS) assessment, dated 10/10/25, indicated Resident 3 was severely impaired cognitively.A facility weight log indicated the following:On 10/4/25, the resident weighed 149 pounds on admission.On 11/14/25, the resident weighed 131.8 pounds.On 11/18/25, the resident weighed 130.3 pounds.Resident 3 had a significant weight loss of 11% from 10/4/25 to 11/14/25.There was no documentation in the clinical record to indicate the resident's representative was notified of the significant weight loss.During an interview, on 12/5/25 at 11:25 a.m., the Director of Nursing (DON) indicated Resident 3 had impaired cognition and the family would need notification.During an interview, on 12/8/25 at 9:48 a.m., Clinical Support Nurse 1 indicated staff would need to notify the family of a significant weight loss.A current facility policy, titled Notification of Change in Condition, dated as last reviewed on 12/17/24 and received from the Clinical Support Nurse 1 on 12/8/25 at 10:00 a.m., indicated .To ensure appropriate individuals are notified of change in condition. The Facility must inform the resident, consultant with the resident's physician and if known notify the resident's legal representative when.A significant change in the resident's physical, mental or psychosocial status.The resident representative/provider should be notified of change in condition or diagnostic testing results in a timely manner.Documentation of notification or notification attempts should be recorded in the resident Electronic health record.3.1-5(a)(2)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to ensure a bed hold policy was provided to the resident and resident's representative at the time of discharge for 1 of 2 resident reviewed for hospitalization. (Resident 81)Findings include:The clinical record for Resident 81 was reviewed on 12/3/25 at 10:25 a.m. The diagnoses included, but were not limited to, hyperlipidemia, obesity, and acute respiratory failure.A nursing progress note, dated 9/18/25 at 12:35 p.m., indicated Resident 81 was found unresponsive and the staff called 911. The resident was transported to the hospital.There was no documentation the bed hold policy was provided to Resident 81 or Resident 81's representative.A clinical discharge observation form, completed on 9/30/25, did not indicate whether the bed hold policy was provided to the resident and the resident's representative.During an interview, on 12/8/25 at 9:48 a.m., Clinical Support 1 indicated staff should provide the bed hold policy to the resident and resident's representative at the time of discharge.A current facility policy, titled Bed Hold Notification, dated as last reviewed on 1/8/25 and received from Clinical Support 1 on 12/8/25 at 10:00 a.m., indicated .Residents and Responsible Parties have a right to be notified verbally and in writing on reserve bed payment policy per the state plan when someone goes out to the hospital.Before transferring a resident a resident to a hospital or allowing a resident to go on a therapeutic leave, the Nursing designee or other designated staff member should provide written information to the resident and a family member or legal representative of the bed hold and admission policies.3.1-12(a)(25)(A)3.1-12(a)(25)(B)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review, the facility failed to ensure a Preadmission Screening and Resident Review (PASARR) was completed after the addition of mental health diagnoses and psychotropic medications for 2 of 4 residents reviewed for PASARR. (Resident 7 and 11)Findings include:1. The clinical record for Resident 7 was reviewed on 12/3/25 at 11:25 a.m. The diagnoses included, but were not limited to, hypertensive chronic kidney disease, atrial fibrillation, a wedge compression fracture of the second lumbar vertebra, major depressive disorder, chronic obstructive pulmonary disease, and dementia without behavioral disturbance. A PASARR level I screening, dated 5/9/24, indicated Resident 7 was not prescribed any mental health medications and did not have any mental health or dementia diagnoses. A physician's order, dated 8/2/24 and discontinued 9/23/24, indicated to administer escitalopram oxalate (an antidepressant medication) 5 milligrams (mg) once a day for depression. On 9/23/24, the escitalopram oxalate order was changed to 10 mg at bedtime for depression. A physician's order, dated 1/19/25 and discontinued 7/15/25, indicated to give bupropion (an antidepressant medication) 75 mg. On 7/15/25 and discontinued 11/12/25, the bupropion order was changed to indicated to 32.5 mg. A physician's progress note, dated 9/18/25 at 11:31 a.m., indicated Resident 7 was being followed for diagnoses of Alzheimer's disease, depression, and anxiety. A care plan, dated 10/13/25, indicated Resident 7 was at risk for developing adverse effects from the use of anti-depressant medications and the resident presented with a diagnosis of depression. During an interview, on 12/1/25 at 2:34 pm., Resident 7 indicated she could not even remember if she had eaten breakfast and she was depressed. During an interview, on 12/4/25 at 10:57 a.m., the Minimum Data Set (MDS) support nurse indicated a new PASARR should be completed with a new diagnosis or a psychotropic medication, such as escitalopram oxalate or bupropion. During an interview, on 12/5/25 at 10:05 a.m., the Social Services Director indicated he had not realized no diagnoses were listed on Resident 7's PASARR or new medications had been added. He would have completed a new PASARR for diagnoses or medications. 2. The clinical record for Resident 11 was reviewed on 12/2/25 at 2:38 p.m. The diagnoses include, but were not limited to, depression, hypertension, and chronic obstructive pulmonary disease. A PASARR level I screening, dated 9/17/25, indicated a level II was not required. Resident 11 had no suspected mental illness, intellectual disability, or related condition and no mental health medications were prescribed. A physician's order, dated 8/4/25, indicated to administer fluoxetine (an antidepressant medication) 20 milligrams once a day for depression. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The PASARR was inaccurate and did not list the fluoxetine or the diagnosis of depression. During an interview, on 12/4/25 at 10:07 a.m., the MDS support nurse indicated typically the mental health medications and diagnosis would be listed on the PASARR A current facility policy, titled Indiana PASRR, undated and received from Clinical Support Nurse 1 on 12/8/25 at 10:00 a.m., indicated .Change in status and Level 2 follow up. Social Services ensure paperwork is submitted. They will print out the outcome letter and upload to Matrix file.Change in status.PASRR Level 1 Complete for change in status. 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure medication carts were free of loose pills and debris, narcotic medications with compromised packaging were destroyed, as needed (PRN) controlled drug use records contained documented of approval by a licensed nurse prior to administration and a pharmacy label for a narcotic medication matched the physician's order for 3 of 4 medication carts reviewed for medication storage and labeling. (100-hall cart 1, 100-hall cart 2 and 200-hall cart 2)Findings include:1. The 100-hall medication cart one (1) was observed on 12/4/25 at 9:12 a.m., and had the following:a. Drawer 2, contained two (2) loose pills and powdered debris collected in the bottom of the drawer against the back wall.b. Drawer 6, the narcotic box, contained a narcotic pill pack of oxycodone 5 milligram (mg) 1/2 tablets. The medication card had not been used for administration and contained 30, 1/2 tablets. Pocket 12 was observed to be compromised and was secured closed with a piece of clear tape; the 1/2 tablet was present in the package.c. Drawer 6, the narcotic box, also contained a narcotic pill pack of oxycodone 5 mg 1/2 tablets. The medication card contained 5 remaining 1/2 tablets. Pockets 11 and 12 were observed with clear tape; the 1/2 tablets were not present in the package.d. A controlled drug use record, with a pharmacy label indicated oxycodone/acetaminophen 5-325 mg with instructions to give 1 tablet by mouth, every 8 hours as needed (PRN) contained 3 out of 6 administrations of the medication by a QMA without a nurse signature or documented nurse approval in the clinical record.e. A controlled drug use record, with a pharmacy label indicated alprazolam 0.5 mg with instructions to give 1/2 tablet (0.25mg) by mouth, three times daily as needed (PRN), for anxiety, contained 4 out of 4 administrations of the medication by a QMA without a nurse signature or documented nurse approval in the clinical record. The pharmacy label on the controlled drug use record did not match the physician's order in the clinical record.The physician's order indicated alprazolam 0.25 mg tablet with instructions to administer 0.25 mg, three times a day.During an interview, on 12/5/25 at 10:45 a.m., LPN 3 reviewed the pharmacy label and indicated the pharmacy label did not match the physician order and the medication needed a change of order or change of directions sticker on the packaging.2. The 200-hall medication cart 2 was observed on 12/4/25 at 8:48 a.m., and had the following:a. Drawer 1, contained one (1) loose pill and powdered debris collected in the bottom of the drawer against the back wall of the drawer.b. Drawer 2 contained one (1) loose pill and powdered debris collected in the bottom of the drawer against the back wall of the drawer.c. Drawer 3, contained one (1) loose pill and powdered debris collected in the bottom of the drawer against the back wall of the drawer.d. Drawer 4, contained two (2) loose pills and powdered debris collected in the bottom of the drawer against the back wall of the drawer.3. The 200-hall medication cart 1 was observed on 12/5/25 at 2:12 p.m., and had the following:a. Drawer 1, contained a 1/2 of a loose pill.b. Drawer 2, contained powdered debris collected in the bottom of the drawer against the back wall of the drawer.c. Drawer 3, contained powdered debris collected in the bottom of the drawer against the back wall of the drawer.d. A controlled drug use record, with a pharmacy label indicated oxycodone/acetaminophen 5-325 mg with instructions to give 1 tablet by mouth, every 4 hours as needed for pain, contained 1 out of 1 administration of the medication by a QMA without a nurse signature or documented nurse approval in the clinical record.During an interview, on 12/4/25 at 9:01 a.m., Licensed Practical Nurse (LPN) 2 indicated pharmacy audits were completed on the medication carts monthly, but nurses were also responsible for checking the carts for loose pills, expired medications, damaged packaging, and keeping the carts clean.During an interview, on 12/5/25 at 2:50 p.m., Unit Manager 5 observed the powder debris at the bottom of the drawers in the 200-hall medication cart and indicated the cart drawers should be wiped out better. She indicated she and another nurse reviewed the carts between the pharmacy cart audits.During an interview, on 12/4/25 at 9:28 a.m., LPN 3 indicated she believed a nurse would need (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to sign for an as needed (PRN) medication when a QMA was administering the medication.During an interview, on 12/4/25 at 9:38 a.m., Unit Manager 4 indicated she was not sure if damaged narcotic medication packaging could be secured with tape.During an interview, on 12/5/25 at 12:09 p.m., QMA 9 indicated if a resident requested medication as needed, she would ask the nurse for approval prior to administering the medication and document the approval in the record.During an interview, on 12/5/25 at 10:05 a.m., the Director of Nursing (DON) indicated some of the QMAs had a nurse sign the controlled drug record and some of the QMAs documented the nurse approval in the clinical record. Pharmacy labels on a medication would not necessarily need to match the physician's order, nor would the nurse need to place a change of order or change of directions label on the medication, if the nurses were checking the 5 rights of administration prior to administering the medication.During an interview, on 12/5/25 at 11:34 a.m., the DON indicated the QMAs were not consistent with documenting if a nurse approved the administration.A document, titled Qualified Medication Aide Scope of Practice, undated and received from the DON on 12/4/25 at 9:45 a.m., indicated .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 do the following.Obtain permission to administer the medication each time.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.A current facility policy, titled Storage of medications, dated as last revised 11/18 and received from Clinical Support Nurse on 12/5/25 at 12:23 p.m., indicated .Medications and biologicals are stored safely, securely, and properly.Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal.Medication storage areas are kept clean.Medication storage conditions are monitored by pharmacy designee and corrective action taken if problems are identified.A current facility policy, titled Administration procedures for all medications, dated as last revised 11/18 and received from the DON on 12/5/25 at 11:37 a.m., indicated .To administer medications in a safe and effective manner.Prior to removing the medication from the container.Check the label against the order on the MAR.A current facility policy, titled Medication Labels, dated as last revised 11/18 and received from the DON on 12/5/25 at 11:36 a.m., indicated .Medications are labeled in accordance with facility requirements and state and federal laws.If the physician's directions for use change or the label is inaccurate, the medication administration personnel may place a [change of order-check chart] label on the container indicating there is a change in directions for use, take care not to cover important label information.3.1-25(b)(8)3.1-25(g)(1)3.1-25(o)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to ensure enhanced barrier precaution signs were posted for residents who required enhanced barrier precaution isolation for 3 of 8 residents reviewed for infection control. (Resident 5, 86 and 87)Findings include: 1. During an observation, on 12/1/25 at 10:18 a.m., Resident 5 had a wound vacuum (a device used to speed up closure by optimizing the wound bed for healing). Resident 5 did not have an enhanced barrier precaution sign posted in or on the outside of the room.During an observation, on 12/1/25 at 11:16 a.m., Resident 5 did not have an enhanced barrier precaution sign posted in or on the outside of the room.During an observation, on 12/1/25 at 12:02 p.m., Resident 5 did not have an enhanced barrier precaution sign posted in or on the outside of the room.During an observation, on 12/1/25 at 2:20 p.m., Resident 5 did not have an enhanced barrier precaution sign posted in or on the outside of the room.The clinical record for Resident 5 was reviewed on 12/4/25 at 2:44 p.m. The diagnoses included, but were not limited to, type 1 diabetes, gas gangrene, and chronic ulcer of the left heel.Resident 5 had a physician's order for a wound vacuum. A physician's order for enhanced barrier precautions was not located at the time of the record review.2. During an observation, on 12/1/25 at 10:26 a.m., Resident 86 had a peripherally inserted central catheter (PICC) line (a type of catheter inserted through a peripheral vein used when intravenous treatment was required over a long period of time). Resident 86 did not have an enhanced barrier precaution sign posted in or on the outside of the room.During an observation, on 12/1/25 at 11:16 a.m., Resident 86 did not have an enhanced barrier precaution sign posted in or on the outside of the room.During an observation, on 12/1/25 at 12:02 p.m., Resident 86 did not have an enhanced barrier precaution sign posted in or on the outside of the room.During an observation, on 12/1/25 at 2:20 p.m., Resident 86 did not have an enhanced barrier precaution sign posted in or on the outside of the room.The clinical record for Resident 86 was reviewed on 12/4/25 at 2:45 p.m. The diagnoses included, but were not limited to, chronic lung disease, respiratory failure, and a history of a stroke.Resident 86 had a physician's order for a PICC line. A physician's order for enhanced barrier precautions was not located at the time of the record review.3. During an observation, on 12/1/25 at 12:42 p.m., Resident 87 did not have an enhanced barrier precaution sign posted in or on the outside of the room.During an observation, on 12/1/25 at 2:20 p.m., Resident 87 did not have an enhanced barrier precaution sign posted in or on the outside of the room.The clinical record for Resident 87 was reviewed on12/4/25 at 2:47 p.m. The diagnoses included, but were not limited to chronic lung disease, inflammatory bowel disease and hypothyroidism.Resident 87 had a physician's order for a catheter. A physician's order for enhanced barrier precautions was not located at the time of the record review.During an interview, on 12/1/25 at 2:29 p.m., the Infection Preventionist indicated the residents should have had an enhanced barrier precaution sign. They did not post the signs in the rooms; signs were placed outside the room. She was not sure why the residents did not have a sign up and they should have. The signs were missing and not posted. A current facility policy, titled Infection Prevention and Control Program, dated as last reviewed 11/19/25 and received upon entrance, indicated .Education and competency assessment to ensure staff follow the IPCP's standards, policies, and procedures. Therefore, staff must be informed and competent. Knowledge and skills pertaining to the IPCP's standards, policies and procedures are needed by all staff to follow proper infection control practices (e.g., hand hygiene and appropriate use of personal protective equipment) .3.1-18(j)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to ensure consents were documented accurately prior to administering a Covid vaccine for 1 of 5 residents reviewed for immunizations. (Resident 51)Findings include: The clinical record for Resident 51 was reviewed on 12/4/25 at 2:15 p.m. The diagnoses included, but were not limited to, acute cystitis without hematuria, anoxic brain damage, elevated white blood cell count, pulmonary fibrosis, dementia, type 2 diabetes mellitus with hyperglycemia, diabetic chronic kidney disease, and aphasia.A Brief Interview for Mental Status (BIMS) assessment, dated 11/6/25, indicated Resident 51 had severe cognitive impairment.A COVID vaccination consent form, dated 1/11/24 at 4:20 p.m., indicated Resident 51's representative refused the COVID vaccination.A COVID vaccination consent form, dated 11/5/25, indicated Resident 51's representative had not signed the consent form for Resident 51 to receive the vaccine. It indicated the Moderna COVID vaccination was given on 11/7/25, in the left arm.A physician's order, dated 11/7/25, indicated the resident received a COVID vaccine and to monitor for side effects three (3) times a day until 11/9/25.During an interview, on 12/4/25 at 12:45 p.m., Resident 51's representative indicated she did not remember any discussion about the resident getting a covid vaccine. She found a band-aid on his arm during a visit and was told he received a shot. She was unaware what shot he had received. She never received any written education on the covid vaccination prior to administration. During an interview, on 12/8/25 at 9:48 a.m., the Infection Preventionist (IP) indicated she had used paper forms instead of the computerized consents to try to keep up with the large number of residents who needed flu and COVID shots this season so everyone who wanted a vaccine would get it.During an interview, on 12/8/25 at 9:50 a.m., the Director of Nursing (DON) indicated consents were required prior to giving a vaccine and the IP must have missed checking the yes box when the resident's representative was there.A current facility policy, titled Guidelines for Influenza, Pneumococcal, and COVID-19, dated 12/17/24 and provided by the DON on 12/8/25 at 10:40 a.m., indicated .each resident/resident representative will be provided with information regarding the risk and benefits of .COVID-19 immunization .each resident/resident representative will sign an informed consent form indicating the acceptance/refusal of immunization 3.1-18(b)(5)