DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRADITIONS AT REAGAN PARK	1176 KINGWOOD DRIVE AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: May 13 and 14, 2025 Facility number: 013264 Residential Census: 81 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 27, 2025.	R 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests Desk Review in lieu a Post Survey Review.	
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency Based on observation, interview, and record review, the facility failed to prevent the potential for accidents when half side rails and mobility bars were installed without initial assessments and/or ongoing monitoring for safety for 3 of 5 residents reviewed for accidents (Residents 14, 15 and 16). Findings include: On 5/13/25 at 10:40 a.m., during an initial tour of the secured memory care unit (MC), Residents 14, 15 and 16's rooms were observed. Resident 14 and 16 both had bilateral half side rails installed to their beds. The side rails to the open side of the bed, were observed to be loose and wobbled when moved. Resident 15's bed was observed to have an under-mattress mobility bar which moved	R 0148	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests Desk Review in lieu a Post Survey Review. **Deficiency:** R148 410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards (e) The facility shall maintain buildings, grounds, and equipment	06/06/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Indi Paysinger	Executive Director	06/04/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRADITIONS AT REAGAN PARK	1176 KINGWOOD DRIVE AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	side to side easily when maneuvered. On 5/14/25 at 10:25 a.m., Licensed Practical Nurse (LPN) 6 indicated she had been a nurse at the facility for almost 4 years and did not recall ever doing side rail assessments for any residents. She did not know who had side rails other than some Hospice residents and the nurses or nursing staff did not conduct any ongoing safety monitoring. LPN 6 indicated Residents 14, 15, and 16 had diagnoses of dementia and would not be able to monitor the effectiveness of the rails for themselves. On 5/14/25 at 10:40 the Maintenance Director observed and measured Residents 14 and 16's side rail. At the narrowest gap, (bottom of the rail to edge of mattress), the Maintenance Director indicated it measured 3.5 inches. From the widest gap, (top of the rail edge to edge of the mattress), was 4.5 inches. The Maintenance Director indicated, the side rails for Residents 14 and 16 were provided and installed by Hospice and he had not done any ongoing safety checks. On 5/14/25 at 10:45 a.m., the Maintenance Director observed Resident 15's under-mattress mobility far. He indicated the family probably brought it in and installed it without letting him know. He lifted the mattress and indicated the bar was not properly secured as only one of the two legs was fastened to the bed-frame. During a follow up interview on 5/14/25 at 10:58 a.m., the Maintenance Director indicated he did not believe there was a Side-Rail policy and had been instructed not to adjust the rails or other durable medical equipment which was supplied by a contracted provider due to liability reasons. Resident 15's family member should have let him		in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. **What corrective actions will be accomplished for those residents found to have been affected by the finding:** Wellness Director or designee will notify third party provider to service loose side rails , request orders from MD and add side rail usage to service plan. Completed by 6/6/25 **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will take place:** Director of wellness or designee will complete an audit of all resident apartments for possible	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRADITIONS AT REAGAN PARK	1176 KINGWOOD DRIVE AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	know, or the nurses should have let him know about the under-mattress mobility bar so that he could ensure it was installed properly. On 5/14/25 at 11:30 a.m., Residents 14, 15 and 16's medical records were reviewed. The records lacked documentation of a physician's order for side rails or mobility bars. The most recent service plans lacked documentation of the side rails or mobility bars installation and ongoing monitoring for safety and appropriateness. The records lacked documentation of any initial and/or ongoing assessments for appropriateness and/or the residents ability to utilize the rails. The record lacked documentation for the purpose of the installation of the side rails, whether for mobility assistance, bed boundaries, or other purposes. On 5/14/25 at 12:08 p.m., the Regional Nurse Consultant provided a copy of a current but undated facility policy titled, "Bed Rails." The policy indicated, "Traditions management will allow residents use of bed rails if it is their preference ... Traditions Management will not provide, replace or manage maintenance on any bed rails or bed mobility devices ... Staff to notify resident, family and/or contracted third party for needs related to bed rails or bed mobility devices ...."		side rail usage, check for safety, obtain an order and add side rail usage to service plan. Audit file to be kept in ED office. Completed by 6/6/25 **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur. How will the corrective actions be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place:** Side rails will be monitored twice a day for safety. We will evaluate the need for side rails upon admission and semiannually. Director of wellness or designee will complete a audit of current side rails to monitor safety, once a week for four weeks then monthly for six months then as needed basis. Audit Log to be kept in the ED office. Completed 6/6/25 and ongoing **What date the systemic changes will be completed:** Completed by 6/6/25 and ongoing	
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency Based on observation, interview, and record	R 0154	The creation and submission of	06/06/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRADITIONS AT REAGAN PARK	1176 KINGWOOD DRIVE AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	review, the facility failed to ensure dry foods and chemical cleaners were stored separately. This deficient practice had the potential to affect 81 of 81 residents residing in the facility. Findings include: On 5/13/25 at 9:45 a.m., dry storage was observed. The facility stored all dry goods in a small shed like building just outside of the kitchen due to size constraints. Upon entering the shed there was a rack of chemicals being stored next to dry food items. The Dietary Manager (DM) indicated he was new to the position, and this was how they had been storing things when he started. He indicated he was unsure whether dry food items and chemicals could be stored together but he would look for a policy. On 5/13/25 at 12:05 p.m. the Executive Director (ED) provided a copy of a current facility policy titled "QRT Chemical Storage", dated 9/1/21. This policy indicated " ...1. All chemicals will be in a separate/secured area ...."		this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests Desk Review in lieu a Post Survey Review. **Deficiency:** R154 410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards – Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. **What corrective actions will be accomplished for those residents found to have been affected by the finding:** Chemicals were removed from dry storage immediately. Completed by 5/13/25 **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will take place:** No residents was adversely affected although the potential for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRADITIONS AT REAGAN PARK	1176 KINGWOOD DRIVE AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			adverse outcome did exists. Chemicals are to be stored separately from food items. Completed by 5/13/25 **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur. How will the corrective actions be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place:** Culinary director to in-service staff on storage of chemicals, new employees will be educated on proper storage of chemicals. Dietary manager or designee to complete audit with part of sanitation monthly audit. Completed by 5/13/25 and ongoing	
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency Based on observations, interviews and record review, the facility failed to notify the physician of a change in a resident's condition after she sustained a skin tear for 1 of 1 resident reviewed for change of condition, (Resident 9). Findings include: On 5/13/25 at 10:41 a.m., Resident 9 was observed in the secured memory care unit. She was seated in a recliner chair with feet pulled up on the leg	R 0214	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests Desk Review in lieu a Post Survey	06/06/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRADITIONS AT REAGAN PARK	1176 KINGWOOD DRIVE AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	rest so that her knees were drawn up which lifted the bottom of her pants leg. A large U-shaped wound with non-approximated edges (cannot be easily brought together). There was a partial scab at the top edge of the wound, but at its widest open area there appeared to be a scant amount of light yellowish drainage. The area which surrounded the wound was discolored as light red that was darkest closer to the wound edges. On 5/13/25 at 1:38 p.m., Resident 9's medical record was reviewed. She resided on the secured memory care unit with a diagnosis of dementia. Her most recent service plan, dated 2/11/25, indicated she required assistance for all activities of daily living (ADLs). A nursing progress note, dated 5/2/25 at 6:23 a.m., indicated, "Resident has a skin tear on her lower left leg. Area cleaned and dressed. Resident has no c/o [complaint of] pain or discomfort at this time." The record lacked documentation of physician notification. The record lacked documentation of wound description/measurements. The record lacked documentation of follow up nurse assessment and/or ongoing monitoring for signs and symptoms of infection. On 5/14/25 at 12:30 p.m., Licensed Practical Nurse (LPN) 6 observed Resident 9's wound. There was an undated treatment in pace at the times which she removed. It was a bunched up swatch of gauze held in place by a cut of compression dressings. LPN 6 removed the treatment and		Review. **Deficiency:** R214 410 IAC 16.2-5-2(a) Evaluation – Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. **What corrective actions will be accomplished for those residents found to have been affected by the finding:** Immediate notification of Physician to obtain treatment order and initiate monitoring of site. Completed by 5/14/25 **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will take place:** Wellness Director or designee will review observation notes daily for four weeks then weekly for four weeks then monthly for four months. Completed by 6/6/25 and ongoing **What measures will be put into place or what systemic**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRADITIONS AT REAGAN PARK	1176 KINGWOOD DRIVE AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated, it was placed earlier that morning when she noticed it had some drainage. LPN 6 described the wound as a skin tear, open, partially scabbed with scant slough at the bottom of the wound edge. LPN 6 indicated there was some red discoloration which could be a sign of infection and she would notify the physician. LPN 6 did not know if the physician had been notified at the time the wound was sustained, but there was not treatment order in her record. On 5/14/25 at 12:08 p.m., the Executive Director provided a copy of an Incident Investigation/Administrative Summary dated 5/2/25. The Incident report indicated, Resident 9 sustained a skin tear as she received assistance to get dressed. The area was cleansed and a dressing was applied at that time. The incident indicated, "Resident received a skin tear while staff was assisting with a.m. ADLs care. QMA [qualified medication aide] on duty was immediately notified and provided aide. Resident unable to provide detail to the account due to cognitive status and diagnosis of dementia." The Incident Investigation report lacked documentation of a witness statement from the nurse aide who performed the ADL a.m. cares. The Incident Investigation report lacked documentation the physician had been notified. The Incident Investigation report lacked documentation of any ongoing treatments needed until healed, and/or monitoring orders for signs/symptoms of infection. A nursing progress note, dated 5/14/25 at 12:37 p.m., indicated, Resident 9 had a skin tear to her left lower extremity, approximately 8 centimeters in		**changes will the facility make to ensure that the deficient practice does not recur. How will the corrective actions be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place:** All clinical staff to be in serviced on process for resident change of condition. Wellness Director or designee will review observation notes daily for four weeks then weekly for four weeks then monthly for four months. Completed by 6/6/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRADITIONS AT REAGAN PARK	1176 KINGWOOD DRIVE AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	length. Left side of skin tear was scabbed, right side was soft with a small amount of "puslike" drainage noted and the area around the wound was red. The physician was notified and a treatment order was requested. During an interview on 5/14/25 at 12:35 p.m., the Director of Nursing (DON) and the Regional Clinical Consultant indicated there was no evidence of documentation that the physician had been notified at the time the resident sustained the wound and there was no documentation of ongoing monitoring. The DON indicated she had not been verbally notified of the skin tear but had seen the nursing progress note. On 5/14/25 at 12:08 p.m., the DON provided a copy of current facility policy titled, "Resident Change in Health Status," reviewed 8/2022. The policy indicated, "It is the policy of this community that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention occurs ... Acute Medical Change: Any sudden or serious change in resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a request for physician visit promptly and or acute care evaluation. The nursing staff will notify the physician ... all nursing actions, physician contacts and resident assessment information will be documented in the nursing progress notes ...."			
R 0301 Bldg. 00	410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency			
	Based on observation and interview, the facility failed to date insulin pens, eye drops, and aplisol (tuberculin testing serum) for 2 of 2 medication	R 0301	The creation and submission of this Plan of Correction does not constitute an admission by this	06/06/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRADITIONS AT REAGAN PARK	1176 KINGWOOD DRIVE AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	carts and 1 of 1 medication rooms. Findings include: On 5/13/25 at 10:29 a.m., the first-floor medication cart was observed. Resident 2 had an insulin pen, basaglar, in the medication cart. It lacked a date to indicate when it was opened. Resident 3 had a bottle of latanoprost 0.005% eye drops in the medication cart. It lacked a date to indicate when it was opened. Resident 4 had a bottle of latanoprost 0.005% eye drops wrapped in an ice pack in the medication cart. It was supposed to be refrigerated until it was opened. It was not opened. In the medication room on the memory care unit was a vial of aplisol 5T (tests) in the refrigerator. It lacked a date to indicate when it was opened. During an interview with the Wellness Director on 5/14/25 at 1:32 p.m., she indicated the eye drops, insulin, and aplisol were good for 28 days. A policy titled, "Medication Storage and Labeling Procedure" was provided by the Wellness Director on 5/14/25 at 12:34 p.m. It indicated, " ...Traditions Management shall assure that the labeling of prescription medicine and drugs meet the following criteria ...."		provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests Desk Review in lieu a Post Survey Review. **Deficiency:** R301 410 IAC 16.2-5-6(c)(5) Pharmaceutical Services – Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. **What corrective actions will be accomplished for those residents found to have been affected by the finding:** Medications were appropriately dated. Completed by 5/13/25 **How will you identify other residents having the potential**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRADITIONS AT REAGAN PARK	1176 KINGWOOD DRIVE AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			to be affected by the same deficient practice and what corrective action will take place: No residents were adversely affected but the potential for adverse outcome did exist. The Wellness Director or designee will audit all med carts to ensure proper labeling. Completed by 5/13/25 **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur. How will the corrective actions be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place:** **All** clinical staff to be in-serviced on proper labeling of medication. Wellness director or designee to complete med cart audit weekly. ED to review med cart audit weekly for four weeks, monthly for four months and then as needed. Documentation to be kept on file in ED office. Completed by 6/6/25 and ongoing	
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance Based on observations, interviews and record reviews, the facility failed to ensure all new admissions had an annual health statement to ensure all residents are free from communicable	R 0409	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth	06/06/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRADITIONS AT REAGAN PARK	1176 KINGWOOD DRIVE AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	diseases (an illness that can be passed from person to person.) for 1 of 3 Residents (Resident 3) who were newly admitted reviewed for annual health statements. Findings include: On 5/14/25 at 11:20 a.m., Resident 3's medical record was reviewed. She was an assisted living resident whose diagnoses included but were not limited to bipolar disorder, cognitive impairment and hypertension. Resident 3 did not have an annual health statement in her electronic medical record. On 5/14/25 at 12:45 p.m., an annual health statement for Resident 3 was requested. On 5/14/25 at 1:15 p.m., the Director of Nursing (DON) indicated they did not have an annual health statement for Resident 3. On 5/14/25 at 2:05 p.m., the Regional Nurse consultant indicated they do not have a specific policy for annual health statements. She indicated they follow Residential Rules.		in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests Desk Review in lieu a Post Survey Review. **Deficiency:** R409 410 IAC 16.2-5-12(d) Infection Control – Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. **What corrective actions will be accomplished for those residents found to have been affected by the finding:** Obtain annual health statement from resident PCP. Completed by 6/6/25 **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will take place:** No residents was adversely affected but the potential for adverse outcome did exist. Annual Health Statement will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRADITIONS AT REAGAN PARK	1176 KINGWOOD DRIVE AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			requested for all current residents. Completed by 5/13/25 **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur. How will the corrective actions be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place:** We are going to obtain Annual Health Statements upon admission and annually thereafter. We will monitor this by completing chart audits post admission and as needed. Clinical staff to be in-serviced on updated admission process. Completed by 6/6/25 and ongoing	