STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK AT LUTHERWOODS	1301 N RITTER AVE, INDIANAPOLIS, , 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00463226. Complaint IN00463226 - No deficiencies related to the allegations are cited. Survey dates: July 21 and 22, 2025 Facility number: 011587 Residential Census: 72 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 24, 2025.	R 0000		
R 0246	Health Services - Deficiency 410 IAC 16.2-5-4(e)(6) (6) PRN medications may be administered by a qualified	R 0246	What corrective action(s) will be accomplished for those Residents found to be affected by the deficient practice: Resident 20 and Resident 25 were not affected by the deficient practice. Director of	08/12/2025

	medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on observation, interview, and record review, the facility failed to ensure Qualified Medication Aide (QMA) staff members received authorization by a nurse prior to administering an as needed (PRN) medication for 2 of 5 residents records reviewed. (Resident 20 and Resident 25) Findings include: 1. The clinical record for Resident 20 was reviewed on 7/21/25 at 3:45 p.m. The diagnoses included, but were not limited to, anxiety. A physician's order, dated 6/6/25, indicated the resident was to receive 8.6-50 milligrams of senna daily PRN. A physician's order, dated 4/23/25, indicated the resident was to receive 0.25 milliliters of morphine PRN. The July 2025 Medication Administration Record (MAR)		Nursing provided immediate education to QMA who gave the PRN medication without authorization by licensed nurse. How the facility will identify other residents to having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents with orders for PRN medications have the potential to be affected. No other residents affected. All licensed nurses and QMAs to be re-educated by 8/12/25 on including but not limited to General Dose Preparation and Medication Administration Policy, PRN medications and QMA job description and scope of practice. What measures will be put into place or what systemic changes the facility will make to ensure that deficient practice does not recur: All licensed nurses and QMAs to be re-educated by 8/12/25 on including but not limited to General Dose Preparation and Medication Administration Policy, PRN medications and QMA job description and scope of practice. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put in place: A PRN medication monitoring tool will be completed weekly x 8 weeks, then bi-weekly x 4 weeks. If 100% threshold is not met, disciplinary action and new action plan will be completed.	

	indicated the following days the senna and morphine PRN were administered by a QMA: morphine - 7/5/25 at 7:23 a.m., and senna - 7/12/25 at 7:11 p.m., 7/18/25 at 7:19 p.m., and 7/20/25 at 3:31 p.m. The resident's clinical record did not indicate the QMA received prior authorization by a nurse to administer the PRN medications. 2. The clinical record for Resident 25 was reviewed on 7/22/25 at 9:45 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus. A physician's order, dated 4/30/25, indicated Resident 25 was to receive five milligrams of oxycodone every four hours PRN. The July 2025 MAR indicated the following days the resident received five milligrams of oxycodone PRN by a QMA: 7/1/25 at 12:39 p.m., 7/9/25 at 12:03 p.m., 4:14 p.m., 7/14/25 at 3:17 p.m., and 7/15/25 at 4:13 p.m. Resident 25's clinical record did		Monitoring tool will be completed by Director of Nursing/designee.	

not include documentation the QMA staff received prior authorization by a nurse to administer the oxycodone to the resident.

An interview was conducted with the Director of Nursing (DON) on 7/22/25 at 9:15 a.m. She indicated she was unable to provide documentation the nurses gave authorization to administer the PRN medications for Resident 20 nor Resident 25. The facility had recently started using electronic MAR documentation. She would provide education to the staff to ensure the QMA staff received prior authorization by the nurses to administer PRN medications.

Based on observation, interview, and record review, the facility failed to ensure Qualified Medication Aide (QMA) staff members received authorization by a nurse prior to administering an as needed (PRN) medication for 2 of 5 residents records reviewed. (Resident 20 and Resident 25)

Findings include:

1. The clinical record for Resident 20 was reviewed on 7/21/25 at 3:45 p.m. The diagnoses included, but were not limited to, anxiety.

A physician's order, dated 6/6/25, indicated the resident was to receive 8.6-50 milligrams

	of senna daily PRN. A physician's order, dated 4/23/25, indicated the resident was to receive 0.25 milliliters of morphine PRN. The July 2025 Medication Administration Record (MAR) indicated the following days the senna and morphine PRN were administered by a QMA: morphine - 7/5/25 at 7:23 a.m., and senna - 7/12/25 at 7:11 p.m., 7/18/25 at 7:19 p.m., and 7/20/25 at 3:31 p.m. The resident's clinical record did not indicate the QMA received prior authorization by a nurse to administer the PRN medications. 2. The clinical record for Resident 25 was reviewed on 7/22/25 at 9:45 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus. A physician's order, dated 4/30/25, indicated Resident 25 was to receive five milligrams of oxycodone every four hours PRN. The July 2025 MAR indicated the following days the resident received five milligrams of oxycodone PRN by a QMA:			

	7/1/25 at 12:39 p.m., 7/9/25 at 12:03 p.m., 4:14 p.m., 7/14/25 at 3:17 p.m., and 7/15/25 at 4:13 p.m. Resident 25's clinical record did not include documentation the QMA staff received prior authorization by a nurse to administer the oxycodone to the resident. An interview was conducted with the Director of Nursing (DON) on 7/22/25 at 9:15 a.m. She indicated she was unable to provide documentation the nurses gave authorization to administer the PRN medications for Resident 20 nor Resident 25. The facility had recently started using electronic MAR documentation. She would provide education to the staff to ensure the QMA staff received prior authorization by the nurses to administer PRN medications.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete.	R 0349	What corrective action(s) will be accomplished for those Residents found to be affected by the deficient practice: Resident 62 was not affected by the deficient practice. Director of Nursing provided immediate education to license nurse that put medication on incorrect flow sheet. Director of Nursing immediately corrected the Lantus to the correct flow sheet.	08/12/2025

	(2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to ensure the medication administration record (MAR) was complete and accurate for 1 of 5 residents' records reviewed. (Resident 62) Findings include: The clinical record for Resident 62 was reviewed on 7/21/25 at 2:34 p.m. The diagnoses included, but were not limited to, diabetes mellitus. A service plan, dated 2/21/25, indicated Resident 62 needed staff assistance regarding medication administration. A physician's order, dated 6/3/25, indicated to administer Lantus (long-acting insulin) 44 units subcutaneously at bedtime. The July 2025 MAR indicated the Lantus was either left blank or documented as "not administered" due to "diabetic", "not on night shift", "insulin", "diabetic clinic", "evening shift", and/or "2nd shift" for 21 out of 21 administrations. During an interview conducted		How the facility will identify other residents to having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents with orders for diabetic medications have the potential to be affected. All diabetic orders reviewed. No other residents affected. All licensed nurses to be re-educated by 8/12/25 on including but not limited to Suggested Medication Administration Procedures and insulin orders to flow sheet on MAR. What measures will be put into place or what systemic changes the facility will make to ensure that deficient practice does not recur:All licensed nurses to be re-educated by 8/12/25 on including but not limited to Suggested Medication Administration Procedures and insulin orders to flow sheet on MAR. New hires will receive education in orientation for correct flow sheet on MAR for diabetic orders. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put in place: A diabetic order monitoring tool will be completed weekly x 8 weeks, then bi-weekly x 4 weeks. If 100% threshold is not met, disciplinary action and new action plan will be completed. Monitoring tool will be completed by Director of Nursing/designee.	

with the Director of Nursing (DON) on 7/22/25 at 1:15 p.m., she indicated there was a MAR and a diabetic MAR. The diabetic MAR was to include insulin administration and blood glucose readings. Resident 62's order for Lantus was put in by a newly employed nurse and they didn't input the order under the correct MAR. The expectations were for the insulin and blood glucose readings to be found on the diabetic MAR; that was where the nursing staff looked to see what active orders were in place for insulin administration.

A policy entitled "Suggested Medication Administration Procedures", revised 6/30/23, was provided by the Floating Clinical Director on 7/22/25 at 1:13 p.m. The policy included, but were not limited to, verify the medication order on the MAR and check against the physician's order, draw up medication dose, and document medication administration.

Based on interview and record review, the facility failed to ensure the medication administration record (MAR) was complete and accurate for 1 of 5 residents' records reviewed. (Resident 62)

Findings include:

The clinical record for Resident

62 was reviewed on 7/21/25 at 2:34 p.m. The diagnoses included, but were not limited to, diabetes mellitus.

A service plan, dated 2/21/25, indicated Resident 62 needed staff assistance regarding medication administration.

A physician's order, dated 6/3/25, indicated to administer Lantus (long-acting insulin) 44 units subcutaneously at bedtime.

The July 2025 MAR indicated the Lantus was either left blank or documented as "not administered" due to "diabetic", "not on night shift", "insulin", "diabetic clinic", "evening shift", and/or "2nd shift" for 21 out of 21 administrations.

During an interview conducted with the Director of Nursing (DON) on 7/22/25 at 1:15 p.m., she indicated there was a MAR and a diabetic MAR. The diabetic MAR was to include insulin administration and blood glucose readings. Resident 62's order for Lantus was put in by a newly employed nurse and they didn't input the order under the correct MAR. The expectations were for the insulin and blood glucose readings to be found on the diabetic MAR; that was where the nursing staff looked to see what active orders were in place for insulin

	administration. A policy entitled "Suggested Medication Administration Procedures", revised 6/30/23, was provided by the Floating Clinical Director on 7/22/25 at 1:13 p.m. The policy included, but were not limited to, verify the medication order on the MAR and check against the physician's order, draw up medication dose, and document medication administration.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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