STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/21/2023

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 the Investigation of Complaint IN00417592. Complaint IN00417592 - State deficiencies related to the allegations are cited at R0240. Survey date: September 21, 2023 Facility number: 011587 Residential Census:76 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on September 25, 2023	R 0000		
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences.	R 0240	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident B has had no adverse effects from	10/12/2023

b. The clinical record for Resident C was reviewed on 9/20/23 11:30 a.m. The Resident's diagnosis included, but were not limited to, arthritis and degenerative disc disease of the lumbar spine.

A physician's order, dated 5/26/23, indicated she was to receive hydrocodone-acetaminophen (narcotic pain medication) 7.5/325 mg (milligram) every 8 hours for pain.

A physician's order, dated 7/15/23, indicated to hold the bedtime dose of hydrocodone/ acetaminophen and to monitor for 72 hours for adverse side effects.

On 9/21/23 at 11:32 a.m. the DON provided a medication/ treatment error report dated 7/15/23 at 2:15 p.m., which indicated the QMA 4 administered the wrong medication. Resident C was given an oxycodone (narcotic pain medication) 7.5 mg/ 325 mg tablet instead of her ordered hydrocodone 7.5/ 325 mg. The physician and the family was notified. The physician gave an order to hold the hydrocodone for the night and to monitor for 72 hours for any adverse effects. QMA 4 was educated on the 3 checks that should be performed before administering

medication error. Resident C has had no adverse effects from medication error.
Resident E has had no adverse effects from medication error.
Resident B has had
no adverse effects from not following the service plan as documented for ADL
care and shower schedule per Resident B’s preference reviewed and in place. QMA 4 received education, counseling, and medication pass review and skills validations 9/25/2023. QMA 5 received education, counseling, and medication
pass review and skills validations 9/24/2023.

**How
the facility will identify other residents having the potential to be affected
by the same deficient practice and what corrective action will be taken:** All residents have the potential to
be affected. No resident was adversely affected. ADL servers per resident
service plans, including but not limited to showers, were reviewed with third
party/home health provider to ensure no other residents had missed showers or
other ADL care. ADL education provided to all qualified staff on 10/2/2023.

	medications. c. The clinical record for Resident E was reviewed on 9/20/23 at 11:40 a.m. The Resident's diagnosis included, but were not limited to, hypertension. Resident E's clinical record indicated he was allergic to Lisinopril (high blood pressure medication). A physician's order dated 8/19/23 indicated to send Resident E to the hospital emergency room for further evaluation and treatment of vomiting and light headedness related to medication error. On 9/21/23 at 11:02 a.m., the DON provided a Medication/ Treatment Error Report, dated 8/19/23, which indicated that QMA 5 had given Resident E another resident's medication. Resident E had received lisinopril, which he was allergic to. Resident E was sent to the emergency room for evaluation. The physician was notified.		Medication pass reeducation completed with all qualified staff on 9/29/2023. QMA 4 received education, counseling, and medication pass review and skills validations 9/25/2023. QMA 5 received education, counseling, and medication pass review and skills validations 9/24/2023. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** All residents have the potential to be affected. No resident was adversely affected. Staff qualified to administer medications reeducated by 10/12/23. Staff qualified to administer medication will be reeducated including but not limited to using the general dose preparation and medication administration assistance or observation policy. Staff qualified to assist with ADL care will be reeducated by DNS/designee on ADL documentation by 10/12/2023. Staff reeducation will include but not limited to ADL documentation.	

A General Dose Preparation and Medication Administration, Assistance and Observation policy received on 9/21/23 at 1:01 p.m. from ED (Executive Director) indicated, the staff should only prepare medication for, or administer medications to, or observe, or assist only one resident at a time.

2. A nursing note for Resident B dated 8/8/23 at 9:03 a.m. indicated, "Resident states that he wants assistance with showers, he states that he has onl[sic, only] had 1 shower since he has been back...writer reached out to [sic, name of Home Health agency], tech [sic] stated that they are working on getting him back on services, but he needs to be seen by his PCP[principal care provider], writer called PCP office to make an appointment, tech [sic] states he has an appointment on 8/31 writer asked to make it sooner, made new appointment for 8/17 @ [sic, at] 2:40pm [sic, p.m.]..."

Resident B's Evaluation Agreement for Residential Healthcare Services and Service Plan, both dated 4/25/23 indicated, Resident B required "standby assistance for bathing 3x [sic, three times] weekly."

Resident B's clinical record, reviewed on 9/21/23 at 11:26 a.m. indicated, he had been discharged to the hospital on 6/24/23 and readmitted on 6/30/23.

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 into place: All residents have the potential to be affected. No resident was adversely affected. Staff qualified to administer medications reeducated by DNS/designee by 10/12/23. Staff qualified to administer medication will be reeducated to include but not limited to using the general dose preparation and medication administration assistance or observation policy. Staff qualified to assist with ADL care will be reeducated by DNS/designee on ADL documentation by 10/12/2023. Staff reeducation will include but not limited to ADL documentation. Medication pass observation tool, resident care/needs and ADL documentation monitoring tool, resident hospital and rehab return monitoring tool will be completed x4 weeks, then monthly x3 months. If 95% threshold is not met, then disciplinary action and new action will be completed. Monitoring tools will be completed by Director of Nursing or Executive Director/designee.

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