STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/09/2025

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 the Investigation of Intake IN00465311. Intake IN00465311 - State deficiencies related to the allegations are cited at R0297. Survey date: October 9, 2025 Facility number: 011587 Residential Census: 57 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 14, 2025.	R 0000		

R 0297	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1) (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on interview and record review, the facility failed to ensure the correct medications were administered to a resident for 1 of 1 resident reviewed for medication errors. (Resident B) Findings include: The clinical record for Resident B was reviewed on 10/9/25 at 10:45 a.m. The diagnoses included, but were not limited to, dermatitis and cataracts. A service plan, dated 4/18/25, indicated she required her medications to be administered by staff. A progress note, dated 9/4/25 at 1:00 p.m., indicated Resident B had been given the wrong medications on accident. The Nurse Practitioner had examined Resident B. Staff would monitor for adverse reactions. The emergency	R 0297	What corrective action(s) will be accomplished for those Residents found to be affected by the deficient practice: Resident B was not affected by the deficient practice. Director of Nursing provided immediate education to the QMA who gave the incorrect medication. 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 on medication administration have the potential to be affected. All licensed nurses and QMAs will be re-educated by 11/14/25 on General Dose Preparation and Medication Administration Policy, including right Resident, right time, right dose and right route. What measures will be put into place or what systemic changes the facility will make to ensure the practice does not recur: All licensed nurses and QMAS to be re-educated by 11/14/25 on General Dose Preparation and Medication Administration Policy.	11/14/2025

	contact had been notified. During an interview on 10/9/25 at 10:50 a.m., the Director of Nursing indicated Resident B had received the following medications in error: two tablets of Tylenol 500 milligrams (mg), one tablet of baclofen (muscle relaxer) 10 mg, and one tablet of cetirizine (antihistamine) 10 mg. During an interview on 10/9/25 at 2:32 p.m., the Director of Nursing indicated the error happened when the Qualified Medication Aide (QMA) was passing medications to two residents at the same time. The QMA had accidentally handed Resident B the other resident's medication and Resident B had taken the pills before the error was noticed. The QMA had been educated on passing medications to one resident at a time. During an interview on 10/9/25 at 2:02 p.m., Resident B indicated she had received the wrong medication a few weeks ago. She had felt kind of funny for about three days and then things were fine. On 10/9/25 at 2:31 p.m., the Director of Nursing provided the General Dose Preparation and Medication Administration policy, last revised 6/30/23, that indicated "...The community		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 medication observation tool will be completed weekly x 8 weeks, then bi-monthly 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.	

staff should only prepare medications for, administer medications to observe or assist only one resident at a time..."

This citation is related to Intake IN00465311.

Based on interview and record review, the facility failed to ensure the correct medications were administered to a resident for 1 of 1 resident reviewed for medication errors. (Resident B)

Findings include:

The clinical record for Resident B was reviewed on 10/9/25 at 10:45 a.m. The diagnoses included, but were not limited to, dermatitis and cataracts.

A service plan, dated 4/18/25, indicated she required her medications to be administered by staff.

A progress note, dated 9/4/25 at 1:00 p.m., indicated Resident B had been given the wrong medications on accident. The Nurse Practitioner had examined Resident B. Staff would monitor for adverse reactions. The emergency contact had been notified.

During an interview on 10/9/25 at 10:50 a.m., the Director of Nursing indicated Resident B had received the following medications in error: two tablets of Tylenol 500 milligrams (mg),

one tablet of baclofen (muscle relaxer) 10 mg, and one tablet of cetirizine (antihistamine) 10 mg.

During an interview on 10/9/25 at 2:32 p.m., the Director of Nursing indicated the error happened when the Qualified Medication Aide (QMA) was passing medications to two residents at the same time. The QMA had accidentally handed Resident B the other resident's medication and Resident B had taken the pills before the error was noticed. The QMA had been educated on passing medications to one resident at a time.

During an interview on 10/9/25 at 2:02 p.m., Resident B indicated she had received the wrong medication a few weeks ago. She had felt kind of funny for about three days and then things were fine.

On 10/9/25 at 2:31 p.m., the Director of Nursing provided the General Dose Preparation and Medication Administration policy, last revised 6/30/23, that indicated "...The community staff should only prepare medications for, administer medications to observe or assist only one resident at a time..."

This citation is related to Intake IN00465311.

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 SIGNATUREJulie Madison	TITLEExecutive Director	(X6) DATE10/23/2025