

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER ROSEWALK AT LUTHERWOODS		STREET ADDRESS, CITY, STATE, ZIP CODE 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 IN00451263 Complaint IN00451263 - State deficiencies related to the allegations are cited at R0064. Survey date: April 10, 2025 Facility number: 011587 Residential Census: 78 This State Residential Findings is cited in accordance with 410 IAC 16.2-5. Quality review completed on April 11, 2025.	R 0000			
R 0064	Residents' Rights- Noncompliance 410 IAC 16.2-5-1.2(hh) (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for	R 0064	What corrective action will be accomplished for those residents found to be affected by the deficient practice - Resident B was not adversely affected. All controlled substances were counted with narcotic count	05/16/2025	

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FORM APPROVED

OMB NO. 0938-0391

investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident.

Based on interview and record review, the facility failed to ensure a medication that was prescribed to a resident was not diverted by a staff person for 1 of 3 residents reviewed for medication misappropriation (Resident B).

Findings include:

The clinical record for Resident B was reviewed on 4/10/25 at 10:15 a.m. The diagnoses included, but were not limited to, chronic pain and polyosteoarthritis (a form of arthritis that affects multiple joints at the same time).

A physician's order, dated 10/21/24, indicated the resident was to receive one hydrocodone-acetaminophen (narcotic pain medication) 10-325 milligrams (mg) tablet every six hours for pain.

On 4/10/25 at 10:42 a.m., the Executive Director (ED) provided an incident report which had been filed with the Indiana Department of Health on 1/13/2025 at 4:30 p.m. The incident report indicated it was discovered that Resident B was missing 12 Norco (brand name for

sheets verified on 1/13/25.

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 with controlled substance orders had the potential to be affected; no other Residents were affected. All controlled substances for Residents were counted with narcotic count sheets verified. Staff qualified to administer medications were educated on Relias and will be re-educated by 5/15/25 on Controlled Substance Policy, including shift to shift count verification and maintaining narcotic count sheets in the resident record.

What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur

Staff qualified to administer medications educated on Relias training assigned on 1/14/25 and will be re-educated by 5/15/25 on Controlled Substance Policy, including shift to shift count verification and maintaining narcotic count sheets in the resident record.

How the corrective actions(s) will be monitored to ensure the

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hydrocodone-acetaminophen) pills, and an investigation had been initiated.

The incident investigation notes were provided by the ED, on 4/10/25 at 10:42 a.m., and included the following:

A statement from Qualified Medication Aide (QMA) 3, dated 1/13/25, indicated, on 1/8/25, Resident B had approximately four to six Norco pills left.

Statements from QMA 2, dated 1/14/25 and 1/16/25, indicated she administered the last Norco pill on the card to Resident B and removed the corresponding narcotic count sheet. She could not remember what was done with the count sheet. She notified Licensed Practical Nurse (LPN) 1 that she gave the last Norco pill and more needed to be ordered.

A statement from LPN 1, dated 1/14/25, indicated, on 1/10/25, QMA 2 told him Resident B was out of Norco pills. He contacted the facility's pharmacy, and the pharmacy tech told him it was too early to be filled. The earliest fill date for the Norco was 1/13/25. He notified LPN 5, the weekend supervisor, at shift change about the Norco situation.

The ED indicated in a statement, dated 1/11/25, that she received a call from LPN 5

deficient practice will not recur, i.e. what quality assurance program will be put into place

A controlled substance monitoring tool will be utilized weekly x 8 weeks, bi-weekly x 4 weeks to ensure compliance. The monitoring tool will be completed by Director of Nursing/designee. If 100% threshold is not meet then disciplinary action and new action plan will be completed.

asking her to approve a cost of \$16.00 to pay for 12 additional Norco pills for Resident B. This was to get the resident through until her insurance would pay for the next refill on 1/13/25.

During an interview on 4/10/25 at 10:30 a.m., the ED indicated she started the investigation after being notified that Resident B was out of Norco and it was too early to be refilled. She contacted the pharmacy and concluded a total of 12 Norco pills were missing. The ED also discovered that there were missing narcotic count sheets for two shipments of Norco from the pharmacy. They were missing 1 of 4 narcotic count sheets from their 11/22/24 shipment. They were also missing 3 of the 4 narcotic count sheets from the 12/18/24 shipment. She believed whoever was diverting the Norco pills also took the narcotic count sheets to cover it up. She asked facility staff to provide statements and complete drug testing. All the staff complied except QMA 4, who indicated she would not do that and walked out of the building. She had not come in to do drug testing and never showed up again for work. The ED thinks she may have been the one diverting because of her actions.

On 4/10/25 at 12:05 p.m., the Director of Nursing (DON)

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provided the Controlled Substance Records for the dates 11/22/24 through 1/13/25. They had received two Norco shipments from the pharmacy, one on 11/22/24 and the other on 12/18/24. Each shipment contained four cards of 30 Norco pills, with one corresponding Controlled Substance Record for each card. Controlled Substance Record # 1, initiated on 11/22/24, was complete and correct. Controlled Substance Record #2's last entry was dated 12/8/24. Controlled Substance Record #3 was missing. Controlled Substance Record #4's first entry was dated 12/12/24. No documentation for 12/9/24, 12/10/24, or 12/11/24 could be located. The last entry on record #4 was dated 12/19/24. Staff then began administering Norco pills from the 12/18/24 shipment on Controlled Substance Record #2, because Controlled Substance Record #1 was missing. The entries started on 12/20/24 and ended on 12/28/24. No other documentation for the dates 12/29/24 through 1/10/25 could be found. The next Controlled Substance Record started on 1/11/25, representing the shipment of 12 Norco pills they had requested when Resident B ran out early.

During an interview on 4/10/25

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at 2:15 p.m., the Assistant Director of Nursing (ADON) indicated the facility had looked for the missing narcotic sheets and were unable to find them. The facility staff put the completed narcotic count sheets in the file box to be scanned. All narcotic sheets from the time period in question should be scanned into Resident B's chart.

On 4/10/25 at 3:31 p.m., the DON provided a policy titled "Controlled Substances", revised on 10/2024. It indicated its purpose was to "prevent diversion, improper use and accidents related to controlled substances ...When a controlled substance is administered to a resident, it must be recorded on the resident's Medication Sheet. Documentation on the Controlled Substance/Schedule II Narcotic Sheet that is created for each prescription [sic] ...In addition to the Medication Sheet and the Schedule II Narcotic Sheet, the number of controlled substances on hand must be counted and verified at the end of each shift ..."

This citation is related to Complaint IN00451263.

Based on interview and record review, the facility failed to ensure a medication that was prescribed to a resident was not diverted by a staff person for 1 of 3 residents reviewed for

medication misappropriation
(Resident B).

Findings include:

The clinical record for Resident B was reviewed on 4/10/25 at 10:15 a.m. The diagnoses included, but were not limited to, chronic pain and polyosteoarthritis (a form of arthritis that affects multiple joints at the same time).

A physician's order, dated 10/21/24, indicated the resident was to receive one hydrocodone-acetaminophen (narcotic pain medication) 10-325 milligrams (mg) tablet every six hours for pain.

On 4/10/25 at 10:42 a.m., the Executive Director (ED) provided an incident report which had been filed with the Indiana Department of Health on 1/13/2025 at 4:30 p.m. The incident report indicated it was discovered that Resident B was missing 12 Norco (brand name for hydrocodone-acetaminophen) pills, and an investigation had been initiated.

The incident investigation notes were provided by the ED, on 4/10/25 at 10:42 a.m., and included the following:

A statement from Qualified Medication Aide (QMA) 3, dated 1/13/25, indicated, on 1/8/25,

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Resident B had approximately four to six Norco pills left.

Statements from QMA 2, dated 1/14/25 and 1/16/25, indicated she administered the last Norco pill on the card to Resident B and removed the corresponding narcotic count sheet. She could not remember what was done with the count sheet. She notified Licensed Practical Nurse (LPN) 1 that she gave the last Norco pill and more needed to be ordered.

A statement from LPN 1, dated 1/14/25, indicated, on 1/10/25, QMA 2 told him Resident B was out of Norco pills. He contacted the facility's pharmacy, and the pharmacy tech told him it was too early to be filled. The earliest fill date for the Norco was 1/13/25. He notified LPN 5, the weekend supervisor, at shift change about the Norco situation.

The ED indicated in a statement, dated 1/11/25, that she received a call from LPN 5 asking her to approve a cost of \$16.00 to pay for 12 additional Norco pills for Resident B. This was to get the resident through until her insurance would pay for the next refill on 1/13/25.

During an interview on 4/10/25 at 10:30 a.m., the ED indicated she started the investigation after being notified that

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This citation is related to Complaint IN00451263.

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

TITLE

(X6) DATE

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SIGNATURE		
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