STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 07/25/2024		
	PROVIDER OR SUPPLIEF			1301 N	ADDRESS, CITY, STATE, ZIP COD RITTER AVE APOLIS, IN 46219		
(X4) ID PREFIX TAG R 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00419589, IN00428111, and IN00434670.  Complaint IN00419589 - No deficiencies related to the allegations are cited.  Complaint IN00428111 - No deficiencies related to the allegations are cited.  Complaint IN00434670 - No deficiencies related to the allegations are cited.  Survey dates: July 23, 24, and 25, 2024  Facility number: 011587  Residential Census: 88  These State Residential Findings are cited in accordance with 410 IAC 16.2-5.  Quality review completed on August 1, 2024.  410 IAC 16.2-5-2(c)(1-4)(d)  Evaluation - Noncompliance		R 0000				
R 0216 Bldg. 00							

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Tyler Brammer Executive Director 08/18/2024

Any defiency statement 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 disclodays 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.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DA			DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	ING		07/25/	/2024
		1		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIE	R			RITTER AVE		
ROSEW/	ALK AT LUTHERW	OODS			IAPOLIS, IN 46219		
NOSEWA	ALK AT LUTTIEKW			INDIAN			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	` '	s weight taken on					
		miannually thereafter.					
	(4) If applicable, the resident 's ability to						
	self-administer me						
	l ' '	n shall be documented in					
	writing and kept ir	n the facility.					
			R 0	216	What corrective action(s	•	08/25/2024
		on, interview, and record			will be accomplished for tho		
		failed to ensure a residents'			residents found to have been	n	
		nister medications by			affected by the deficient		
		dministration evaluation for 2			practice;		
		rved with medications in their			Resident 87 had no adverse		
	rooms. (Residents 20 and 87)				effects from self-administering		
					medications without assessme	ent.	
	Findings include:				Resident 20 had no adverse		
					effects from self-administering		
		ord for Resident 87 was			medications without assessme	ent.	
		4 at 1:00 p.m. The diagnoses			Resident 87 had		
		ot limited to, somatization			self-administration assessmer		
		ion of physical symptoms of a			completed on 7/24/24. Reside	nt	
	1	on such as anxiety), diabetes			20 had self-administration		
		n's syndrome (an immune			assessment completed on		
	1 -	mainly causes dry eyes, dry			7/24/24. Resident 87 had OT0		
	mouth and difficult	y swallowing).			medications labeled at bedsid		
					completed on 7/24/24. Reside		
		nistration observation with			20 had OTC medications labe	led	
		Nurse (LPN) 2 was conducted			at bedside completed on		
		a.m. During the medication			7/24/2024.		
		Resident 87, it was observed			How the facility will		
		ne counter (OTC) medications			identify other residents having	_	
		TC medications were a bottle of			the potential to be affected b	_	
		Theraworx foam, a bottle of			the same deficient practice a		
		a bottle of a store brand allergy			what corrective action will be	е	
		of the OTC medications had			taken;	4: _1	
	labels affixed to them to indicate the resident's				All residents have the poten		
	name.	name.			to be affected. No resident wa	IS	
					adversely affected. DNS was		
		nt medication orders received,			reeducated on 7/24/24 regard	ıng	
		p.m., from Director of Nursing			the residents' rights to		
1	(DON), indicated the	he following:	1		self-medicate policy. All reside	ents	I

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	TIPLE CONSTRUCTION (X3) DATE S		SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	NG		07/25/	/2024
				·			
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
					RITTER AVE		
ROSEW	ALK AT LUTHERW	OODS		INDIAN	APOLIS, IN 46219		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWING BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE
					will be interviewed to see if the	ev	
	- To instill one or to	wo drops of Artificial Tears			have OTC medications in their	•	
		nce a day as needed. "MAY			apartments, proper labeling is		
	KEEP AT BEDSIDE".				affixed, and self-administration		
	- Give 2 sprays of Nasal Spray 0.05% into each				assessments completed for th		
		urs as needed for congestion			who wish to self-administer		
	"*MAY KEEP AT				medications by 8/22/24 by		
	- Apply two pumps	of Theraworx relief foam to			DNS/designee. Audit to be		
		eded "***MKAB*** [sic, may			completed to ensure all reside	nts	
	keep at bedside]".	, ,			who self-administer medication		
		ne mist nose spray once in each			have appropriate assessment		
		ded "*MAY KEEP AT			8/22/24 by DNS/designee.	-,	
	BEDSIDE*".				What measures will be		
					put into place or what system	nic	
	A Self-Administrat	ion of Medication Review for			changes the facility will make		
	Resident 87 was da	ted 9/22/24. An interview			to ensure that the deficient	_	
		Director of Nursing (DON), on			practice does not recur;		
		., indicated Resident 87's			All residents will be interview	ved	
	_	n of Medication Review should			to see if they have OTC		
		22/23 as it was completed when			medications in their apartment	ts.	
		mitted to the facility. The DON			and self-administration	,	
		to self-administer medications			assessments completed for th	ose	
		bi-annually however, the			who wish to self-administer		
		sure Resident 87's bi-annual			medications by 8/22/24 by		
		of medication review was			DNS/designee. Audit to be		
	completed.				completed to ensure all reside	nts	
					who self-administer medication		
	2. The clinical reco	ord for Resident 20 was			have appropriate assessment	by	
	reviewed on 7/24/2	4 at 1:05 p.m. The diagnoses			8/22/24 by DNS/designee.		
	included, but was n	ot limited to, dysphagia			How the corrective		
	(difficulty with swa	allowing), chronic kidney			action(s) will be monitored to	)	
	disease, diverticulo	sis, and other symptoms and			ensure the deficient practice		
		ood and fluid intake.			will not recur, i.e., what quali		
					assurance program will be p	-	
	A medication administration observation with				into place;		
	LPN 2 was conducted on 7/24/24 at 9:13 a.m.				All residents will be interview	ved	
	During the medication administration with				to see if they have OTC		
	Resident 20, it was observed that he had over the				medications in their apartment	ts,	
	· ·	lications in his room. The OTC			and self-administration		
	medications consisted of a bottle of Tylenol				assessments completed for th	ose	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ľ	ILDING	nstruction 00	(X3) DATE COMPL <b>07/25</b> /	ETED	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 1301 N RITTER AVE INDIANAPOLIS, IN 46219					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
TAG	(acetaminophen) an antacid). Neither m them to indicate of an ancillary order or might of acetaminoph sources. Resident 2 contain an order for the indicate of the indicate of the follow completed self-administration appropriateThe contains the indicate of the resident's cognitability to carry out apolicyFor those resulf-administration appropriate, the resulf-administration and reason in the indicationsRead the prescripDemonstrate sufficiently committed the predications and she should notify committed the indications and she should notify committed them.	da a bottle of Mylanta (an edication had labels affixed to be resident's name.  Int medication orders received, o.m., from the DON, indicated to acetaminophen 325 mg 6 hours as needed for pain with frot to exceed 4 grams/4000 en in a 24 hour period from all 20's medication orders did not Mylanta.  Interest with the DON, on 7/24/24 ted Resident 20 did not have a ministration of medication  It to Self-Medicate policy 4 at 1:19 p.m., from the DON, wing, "ProcedureThe assess and determinewhether of medications is safe and community may routinely assess tive, physical and visual self-medication per community esidents for which of medications is safe and ident should be able to: determine medications, state the factor of the confortuse of his/her tion label. decient manual dexterity to		TAG	who wish to self-administer medications by 8/22/24 by DNS/designee. Audit to be completed to ensure all reside who self-administer medication have appropriate assessment 8/22/24 by DNS/designee. Self-administration monitoring to be completed weekly x4 we then monthly x3 months. Resinterviews completed weekly then monthly x3 months to en OTC bottles in apartments are identified and labeled appropriately. If 90 percent threshold is not met, then disciplinary action and new activity be completed. Monitoring will be completed by DNS or ED/designee.	ents ns by tool eeks, dent k4, sure	DATE	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION (X) A. BUILDING (D0) B. WING		COMPL	X3) DATE SURVEY  COMPLETED  07/25/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1301 N RITTER AVE INDIANAPOLIS, IN 46219				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
R 0273 Bldg. 00	community staff she self-administration ones, how much, he conducted by the w nurse with each self-identify medication 410 IAC 16.2-5-5. Food and Nutrition (f) All food prepara (excluding areas i maintained in accolocal sanitation an standards, including	ould document the of medications (i.e., which ow often)A review is ellness director or licensed f-medicating resident to usage and changes."  1(f) nal Services - Deficiency ation and serving areas in residents ' units) are ordance with state and d safe food handling	R 02		What corrective action(s	<b>3</b> )	08/25/2024
	handling of stored for use-by or expiration and local sanitation standards in the kitch affect 88 of 88 residents. A kitchen tour and on 7/23/24 at 10:30 storage area housed open date, of 3/8/24 and a bottle of Lee date, of 5/2/23, and walk-in refrigerator olives with an open date, of 7/21/24, an carrots with use by preparation area hor spice with an open date, of 6/8/24, and	failed to ensure the correct food items that were past the a date in accordance with state and safe food handling then with the potential to dents in the facility. (Facility)  observation were conducted, a.m., with Cook 2. The dry a package of cake mix with an discard date, of 6/8/24, and Perrins sauce with an open a discard date of 5/3/24. The housed a container of black date, of 7/16/24, and a use by date of 7/18/24. The food used a container of parsley date, of 6/28/23, and a use by a container of dill spice with 1/23, and a use by date of			will be accomplished for those residents found to have been affected by the deficient practice;  No residents were adversely affected related to improper food labeling. Culinary staff received reeducation on 8/16/24 regarding proper food labeling standards. No residents were adversely affected related to improper food handling standards in the kitchen. Culinary staff received reeducation regarding proper food handling by 8/16/24.  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 had the potential to be affected. No residents were adversely affected related to improper food labeling. Culinary		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  07/25/2024		
	PROVIDER OR SUPPLIER		1301 N	STREET ADDRESS, CITY, STATE, ZIP COD 1301 N RITTER AVE INDIANAPOLIS, IN 46219		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
IAG	An interview was co a.m., with Cook 2. S should be discarded expiration, discard be A current facility po 5/24, was provided on 7/25/24 at 10:55 following, "Sufficie provided to keep for appetizingThe for the name of the pro- and marked to indice shall be consumed of with the date the ori the date by which the	onducted, on 7/23/24 at 10:45 She indicated that food items when it reached the date of by, or use-by date.  Dicy titled Food Storage, dated by the Executive Director (ED) a.m. The policy indicated the nt storage facilities are ods safe, wholesome, and od must clearly be labeled with duct, the date it was prepared, ate the date by which the food or discardedClearly marked ginal container is opened and ne food shall be consumed or rage foods shall be covered or	IAG	staff received reeducation on 8/16/24 regarding proper food labeling standards. No reside were adversely affected relate improper food handling standard in the kitchen. Culinary staff received reeducation regarding proper food handling on 8/16/Audit of all food storage areas be completed for proper food storage practices by 8/22/24.  What measures will be put into place or what system changes the facility will make to ensure that the deficient practice does not recur;  Culinary staff received reeducation on 8/16/24 regard proper food labeling standard Culinary staff received reeducated on facility food storage areas to be completed proper food storage practices 8/22/24.  How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what qual assurance program will be proper food handling on 8/16/24 regarding proper folabeling standards. Culinary staff received reeducation regarding proper food handling on 8/16/24 regarding proper folabeling standards. Culinary staff to be reeducated reeducation regarding proper food handling on 8/16/24 regarding proper folabeling standards. Culinary staff to be reeducated focility food storage policy by storage policy storage policy storage policy storage policy storage policy st	nts ed to eards g 24. s to  mic e  ding s. eation g on  brage food d for by  c ity ut  eation cod taff g 24.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPL	ETED
			B. W.	ING		07/25/	2024
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
ROSEWA	ALK AT LUTHERWO	OODS		INDIANAPOLIS, IN 46219			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE
					8/16/24. Food storage monitor tool to be completed weekly x-	_	
					then monthly x3. If 90 percent		
					threshold is not met, then		
					disciplinary action and new ac	tion	
					will be completed. Monitoring		
					will be completed by CM or		
					ED/designee.		
R 0297	410 IAC 16.2-5-6(						
DI4= 00		ervices - Noncompliance					
Bldg. 00	, ,	ontrols, 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.						
			$R_0$	297	What corrective action(s	s)	08/25/2024
	Based on observation	on, interview, and record		_,,	will be accomplished for tho	· .	00/20/2021
	review, the facility	failed to ensure a resident's			residents found to have been		
	extended release blo	ood pressure medication,			affected by the deficient		
	which indicated on	its packaging "do not chew or			practice;		
		was not being crushed by the			All residents with ancillary		
		nistering medications; not			orders for crushed medication		
		nt's physician of such			have the potential to be affect	ed.	
	_	armacy not addressing a			Resident 87 had no adverse		
	-	irregularity concerning an			effects from crushing medicati		
	-	ch indicated, "may crush			with an indication of not to cru	sh.	
		pharmacy warning label onot to crush or chew" on the			Resident 87 had no adverse		
	medication packagi				effects from not notifying phys		
	medication packagn	ing. (Resident 6/)			of crushing medications with a indication of not to crush.	111	
	Findings include:				Resident 87 had not adverse		
	i maniga metude.				effects from pharmacy not		
	A medication obser	vation for Resident 87 was			addressing irregularities with		
					ancillary order which indicated	,	
		conducted with Licensed Practical Nurse (LPN) 2 on 7/24/24 at 8:50 a.m. In preparation to			may crush medications. MD		
		administer Resident 87's morning medications, it			contacted with clarification giv	en	
		sident's Nifedipine (a blood			7/26/24. LPN 2 reeducated on		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. WI	NG		07/25/	2024
			<u> </u>	STREET 4	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	R			RITTER AVE		
ROSEW/	ALK AT LUTHERW	OODS			APOLIS, IN 46219		
	LICATI LOTTILITATI			INDIAN	7.1 JEIO, III 702 IV		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	^	medication) 90 mg ER (extended			physician notification and read	ling	
		nd a pharmacy warning label			medication indications and		
		ated not to crush or chew the			medication pass observation		
		entered her room to administer			completed with LPN 2. Staff		
	her medications and Resident 87 sat at a small				qualified to pass medications		
	table which had two pill crushers sitting on the				reeducated on reading medica		
	table in front of her. She indicated she has an				indications. Staff qualified to p	ass	
		ing some of the medications so,			medications completed		
	_	usher to make it easier for her			medication pass observation.		
		ne had commented she has			Nursing staff educated on		
		sion and after she had crushed			physician notifications.		
		e used her finger to ensure no			Pharmacist consultant to revie		
		t in the pill crusher then took			all residents with ancillary orde		
	the medications.				that can crush medications for		
	T ''	LIDNIA 1 ( 1			irregularities by 8/22/24.		
		h LPN 2 conducted,			How the facility will		
		exiting Resident 87's room,			identify other residents having	_	
		on Resident 87's July 2024			the potential to be affected b	-	
	1	Administration Record) did not tion should not be crushed or			the same deficient practice a		
		ed an ancillary order which			what corrective action will be	•	
		crush medications. LPN 2			taken;		
		that ancillary order of may			All residents with ancillary orders for crushed medication	•	
		meant the medications on her				-	
		eviewed and it was ok to crush			have the potential to be affected Resident 87 had no adverse	ŧu.	
		s on her med list. LPN 2 had			effects from crushing medicati	ono	
	1 -	nt 87's physician about the			with an indication of not to cru		
		ne medications herself.			Resident 87 had no adverse	511.	
	resident crusining th	ic medications hersen.			effects from not notifying phys	ician	
	An interview condu	acted with Resident 87's Nurse			of crushing medications with a		
		urse, on 7/24/24 at 11:24 a.m.,			indication of not to crush.	11	
		87's NP had not been made			Resident 87 had not adverse		
					effects from pharmacy not		
	aware of her crushing her medications herself.  The NP's nurse indicated she had received an				addressing irregularities with		
	order from the NP that they were going to change				ancillary order which indicated		
	the extended release Nifedipine to an immediate				may crush medications. LPN 2		
	release since the resident crushed the medications				reeducated on physician	-	
	herself.				notification and reading medic	ation	
	nersen.				indications and medication par		
	A Storage and Eve	iration Dating of Medications,			observation completed with LF		
	11 Storage and Expi	nation Dating of Medicalions,			l opaci varion combiered with Fr	IN Z.	

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00  B. WING		COMPLETED 07/25/2024	
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD		
ROSEWA	ALK AT LUTHERWO	OODS		IAPOLIS, IN 46219		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
IAU	Biologicals policy rep.m., from the Direct following, "General community should e refrigerator, freezer medications and bio community should emedications and bio worn, makeshift, included labelsBedside medications or biological medications or biological properties."	eceived on, 7/25/24 at 12:33  tor of Nursing, indicated the storage proceduresThe ensure food is not stores in the or general storage areas where logical are storedThe elestroy and reorder logicals with soiled, illegible, complete, damaged or missing dication storageThe administer/provide bedside ogicals without a corder and approval by	IAU	Staff qualified to pass medical reeducated on reading medical indications. Staff qualified to pass medical medications completed medication pass observation. Nursing staff educated on physician notifications. Pharmacist consultant to revie all residents with ancillary ord that can crush medications for irregularities. Resident intervie to determine crush preference 8/22/24. Audit of all residents ancillary orders to crush medications reviewed for irregularities by 8/22/24.  What measures will be put into place or what system changes the facility will make to ensure that the deficient practice does not recur;  LPN 2 reeducated on physical notification and reading medical indications and medication passervation completed with LI Staff qualified to pass medical reeducated on reading medical indications. Staff qualified to pass medical reducated on physician notifications. Pharmacist consultant to review all residents with ancillary ord that can crush medications for irregularities by 8/30/24. Staff qualified to administer medical in-serviced on storage and expiration dating of medication biologicals policy by 8/30/24.	ew ers r ews es by with  mic e  cation ss PN 2. tions ation nass	

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  07/25/2024	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 1301 N RITTER AVE INDIANAPOLIS, IN 46219				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  NOT MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
					How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what qual assurance program will be pinto place;  LPN 2 reeducated on physic notification and reading medicindications and medication parabservation completed with LI Staff qualified to pass medica reeducated on reading medicindications. Staff qualified to periodications completed medication pass observation. Nursing staff educated on physician notifications. Pharmacist consultant to revie all residents with ancillary ord that can crush medications foirregularities by 8/30/24. Staff qualified to administer medica in-serviced on storage and expiration dating of medication biologicals policy by 8/30/24. Medication storage and expiration dating of medications, biologic monitoring tool completed we x4 and monthly x3. If 90 percent threshold is not met, then disciplinary action and new activities will be completed. Monitoring will be completed by DNS or ED/designee.	eity out cian cation ass PN 2. tions ation bass ew ers r ations ation cals ekly ent	
R 0300	410 IAC 16.2-5-6 Pharmaceutical S	(c)(4) services - Deficiency					
Bldg. 00	(4) Over-the-cour drugs, and biolog	nter medications, prescription icals used in the facility n accordance with currently					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
			B. Wl	VING 07/25/2024			
				STREET	ADDRESS, CITY, STATE, ZIP COD		_
NAME OF I	PROVIDER OR SUPPLIEF	8			RITTER AVE		
ROSEWA	ALK AT LUTHERW	OODS		INDIANAPOLIS, IN 46219			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	· ·	onal principles and include					
	instructions and the	ccessory and cautionary					
		ie expiration date.	R 0.	200	What corrective action(s	s) 08/25/2024	
	Based on observation, interview, and record		I K U.	300	will be accomplished for tho	-	r
		also failed to ensure its			residents found to have been		
	-	practices followed accepted			affected by the deficient	'	
	_	uidelines by not labeling two			practice;		
		TC) medications in the			Resident 17 had no adverse	,	
	·	room with required information			effects from not ensuring the		
	and not ensuring a	resident's insulin pens were			resident's insulin pens were		
	labeled with the nec	cessary information (Resident			labeled with the necessary		
17).				information. No residents were	е		
					affected by OTC medications	not	
	Findings include:				being labeled in the medicatio	n	
					storage room. LPN 2 and all s	taff	
		ministration observation was			qualified to administer insulin		
	· ·	24 at 11:00 a.m., with LPN 2.			reeducated on storage and		
		to get Resident 17's insulin for			expiration dating of medication		
	-	bulled down a basket which			and biologicals. All staff qualif	ied	
		oom number on it. Inside the			to administer medications		
		sulin pens, one was aspart			reeducated on storage and		
		n) and the other was glargine			expiration dating of medication	ns	
		). Neither of the pens were ident's name, prescription			and biologicals.		
		s name, or name of the			How the facility will identify other residents having	na	
		d the prescription affixed to the			the potential to be affected b		
	pen.	rr non annoa to the			the same deficient practice a	·	
	1				what corrective action will be		
	2. An observation	of the medication room was			taken;		
	completed with Ass	sistant Director of Nursing			All residents have the poten	tial	
	(ADON) on 7/25/24	4 at 10:45 a.m. In the medication			to be affected. Resident 17 ha		
	room, there were tw	vo over the counter (OTC)			adverse effects from not ensu	ring	
	medications. One v	cations. One was Striction D (a blood sugar			the resident's insulin pens wer	re	
	supplement), and the other was Phytoplex (an				labeled with the necessary		
	antifungal) powder. Neither of these medications				information. No residents were	- I	
	had resident labels affixed to them. The ADON				affected by OTC medications		
	indicated they were unable to identify what				being labeled in the medicatio		
	resident the medica	tions were for.			storage room. LPN 2 and all s	taff	
		1		qualified to administer insulin			

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	•	SURVEY LETED /2024
	PROVIDER OR SUPPLIEI		1301 N	ADDRESS, CITY, STATE, ZIP COI N RITTER AVE NAPOLIS, IN 46219	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ICTION ULD BE PROPRIATE	(X5) COMPLETION DATE
	A Storage and Expr Biologicals policy of p.m., from the Direct following, "General community should refrigerator, freezer medications and bio- community should medications and bio- worn, makeshift, in labelsBedside me- community may no medications or biol	received on, 7/25/24 at 12:33 ctor of Nursing, indicated the l storage proceduresThe ensure food is not stores in the or or general storage areas where plogical are storedThe destroy and reorder plogicals with soiled, illegible, complete, damaged or missing dication storageThe t administer/provide bedside ogicals without a r order and approval by		reeducated on storage a expiration dating of med and biologicals. All staff to administer medication reeducated on storage a expiration dating of med and biologicals. DNS/de audit medication storage identify any irregularities medication labeling and by 8/23/24. DNS/designe insulin storage to identify irregularities in labeling a insulin storage by 8/23/2  What measures wi put into place or what schanges the facility will to ensure that the defice practice does not recur LPN 2 and all staff qualimister insulin reeducations and biologic staff qualified to administed medications and biologic staff qualified to administed and expiration designed and expiration designed and expiration designed insulin storage and expiration designed insulin storage to audit in storage room to identify irregularities in medication and storage by 8/23/24. DNS/designee to audit in storage to identify any irregularities in labeling a insulin storage by 8/23/24. DNS/designee to audit in storage to identify any irregularities in labeling a insulin storage by 8/23/24. How the corrective action(s) will be monitod ensure the deficient prawill not recur, i.e., what assurance program will	ications qualified as and ications signee to e room to s in storage ee to audit y any and dating 24. ill be systemic I make cient ; alified to cated on ating of cals. All ter on ating of cals. All ter on ating of cals. nedication any on labeling nsulin and dating 24. e ored to actice c quality	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE S COMPLI 07/25/	ETED				
NAME OF PROVIDER OR SUPPLIER ROSEWALK AT LUTHERWOODS			STREET ADDRESS, CITY, STATE, ZIP COD 1301 N RITTER AVE INDIANAPOLIS, IN 46219						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ECTION ULD BE PROPRIATE	(X5) COMPLETION DATE			
				into place; LPN 2 and all staff qua administer insulin reedule storage and expiration of medications and biologic staff qualified to administ medications reeducated storage and expiration of medications and biologic DNS/designee to audit in storage room to identify irregularities in medication and storage by 8/23/24. DNS/designee to audit in storage to identify any irregularities in labeling a insulin storage by 8/23/2 Medication storage audicompleted weekly x4 an monthly x3. Insulin storaccompleted weekly x4 an monthly x3. If 90 percentor met, then disciplinary and new action will be considered will monitoring tools.	cated on lating of cals. All ster on lating of cals. nedication any on labeling nsulin and dating 24. t d then age audit d then t threshold y action ompleted.				
R 0407	410 IAC 16.2-5-12 Infection Control -								
Bldg. 00	control program the (1) A system that analyze patterns of symptoms. (2) Provides orient education on infectional including universal (3) Offering health	n information to residents, limited to, infection							

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  A. BUILDING B. WING  OU COMPLETED 07/25/2024  STREET ADDRESS, CITY, STATE, ZIP COD 1301 N RITTER AVE INDIANAPOLIS, IN 46219  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION  (4) Reporting communicable disease to public health authorities.  R 0407 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient
NAME OF PROVIDER OR SUPPLIER  ROSEWALK AT LUTHERWOODS  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (4) Reporting communicable disease to public health authorities.  (4) Reporting communicable disease to public health authorities.  Resultation interview, and record review, the facility failed to maintain an infection  RESTREET ADDRESS, CITY, STATE, ZIP COD 1301 N RITTER AVE INDIANAPOLIS, IN 46219  (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)  REQUILATORY OR LSC IDENTIFYING INFORMATION  REQUILATORY OR LSC IDENTIFY INFORMATION  REQUILATORY OR LSC IDENTIF
ROSEWALK AT LUTHERWOODS  INDIANAPOLIS, IN 46219  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG  (4) Reporting communicable disease to public health authorities.  REGULATORY OR LSC IDENTIFYING INFORMATION  REGULATORY OR LSC IDENTIFYING I
ROSEWALK AT LUTHERWOODS  INDIANAPOLIS, IN 46219  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG  (4) Reporting communicable disease to public health authorities.  REGULATORY OR LSC IDENTIFYING INFORMATION  REGULATORY OR LSC IDENTIFYING I
ROSEWALK AT LUTHERWOODS  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION  (4) Reporting communicable disease to public health authorities.  (4) Reporting communicable disease to public health authorities.  R 0407  What corrective action(s) will be accomplished for those residents found to have been
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG (4) Reporting communicable disease to public health authorities.  R 0407 What corrective action(s) will be accomplished for those review, the facility failed to maintain an infection (X5) COMPLETION DATE
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  (4) Reporting communicable disease to public health authorities.  (4) Reporting communicable disease to public health authorities.  (A) Reporting communicable disease to public health authorities.  (BACH DEFICIENCY)  (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (A) Reporting communicable disease to public health authorities.  (B) What corrective action(s) will be accomplished for those residents found to have been
TAG REGULATORY OR LSC IDENTIFYING INFORMATION  (4) Reporting communicable disease to public health authorities.  REGULATORY OR LSC IDENTIFYING INFORMATION  (A) Reporting communicable disease to public health authorities.  Regulatory or LSC IDENTIFYING INFORMATION  TAG CROSS-REFERENCED TO THE APPROPRIATE DATE  OATE  REGULATORY OR LSC IDENTIFYING INFORMATION  TAG What corrective action(s) will be accomplished for those residents found to have been
(4) Reporting communicable disease to public health authorities.  R 0407 What corrective action(s) 08/25/2024  Based on observation, interview, and record review, the facility failed to maintain an infection 08/25/2024
public health authorities.  R 0407  What corrective action(s)  Will be accomplished for those review, the facility failed to maintain an infection  O8/25/2024
Based on observation, interview, and record review, the facility failed to maintain an infection  R 0407  What corrective action(s) will be accomplished for those residents found to have been
Based on observation, interview, and record review, the facility failed to maintain an infection will be accomplished for those residents found to have been
review, the facility failed to maintain an infection residents found to have been
I control program by foliching the rim and/or inside
of a medication cup and/or water cup (Residents practice;
84 and 58), not maintaining a clean technique  Resident 84 had no adverse
when preparing medications (Residents 20, 84,
and 58), touching medications with bare hands  and inside of medication cup and
(Residents 20, 84, and 58) and not cleaning an water cup. Resident 58 had no
insulin pens' rubber hub prior to placing a sterile  adverse effects from staff touching
needle (Residents 17 and 72). the rim and inside of medication
cup and water cup. Resident 20
The facility failed to ensure kitchen staff followed had no adverse effects from staff
facility guidelines for the use of gloves in not maintaining a clean technique
processing food orders causing possible cross during medication preparation.
contamination with the potential of affecting 1 out  Resident 84 had no adverse
of 5 residents eating meals prepared in the kitchen  effects from staff not maintaining a
grill area. (Facility)  clean technique during medication
preparation. Resident 58 had no
Findings include:  adverse effects from staff not
maintaining a clean technique 1. A medication administration observation was during medication preparation.
conducted, on 7/24/24, with Licensed Practical  Resident 17 did not have any
Nurse (LPN) 2 and the following was observed:  Action of the following was observed:  Action of the following was observed:  Action of the following was observed:
cleaning insulin pens' rubber hub
a. At 9:13 a.m., LPN 2 was preparing to dose prior to placing sterile needle.
Resident 20's morning medications. LPN 2 picked  Resident 72 did not have any
up a medication cup to write the resident's room  adverse effects from staff not
number on it, when he did, he placed his index  cleaning insulin pens' rubber hub
finger into the cup and pinched the cup between prior to placing sterile needle. No
his index finger and thumb to write on the cup.  his index finger and thumb to write on the cup.  residents had adverse effects from
LPN 2 performed hand hygiene then touched the staff not following glove guidelines
medication carts drawer handle to pull out a in the kitchen. LPN 2 provided
medication pill card. When dispensing the reeducation on medication
medications into the medication cup, LPN 2 would administration procedures and
pop the pills from the pill card into his hand and skills validation completed. LPN 2
then dump the pill into the medication cup with provided reeducation on insulin
each of the medications that were to be given.  administration procedures and

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		B. W	B. WING		07/25/2024		
				CTREET	ADDRESS SITE STATE SID COD		
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
DOOEW	ALIZ AT LUTUED\A/	0000			RITTER AVE		
RUSEW	ALK AT LUTHERW	OODS		INDIAN	APOLIS, IN 46219		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	DATE	
	LPN 2 did not pull	all the medication pill cards at			skills validation completed. Co	ok 3	
	once but rather he p	pulled one card at a time. So, he			provided reeducation on glove	use	
	was repeatedly touc	ching a medication cart drawer			in the kitchen, handwashing a	nd	
		g the pills out into his hand			glove use skills validation		
		in the cup. LPN 2 repeated			completed by 8/23/24.		
	_	etween preparing Resident 20's			How the facility will		
		pressure medication),			identify other residents having		
		medication), magnesium oxide			the potential to be affected b	у	
		nt), metoprolol (blood pressure		the same deficient practice and		nd	
		razole (an acid reducer), and			what corrective action will be		
	, ,	overactive bladder), potassium			taken;		
	(supplement), sodium bicarbonate (an antacid),				All residents have the potent		
	and torsemide (treats fluid retention).				for adverse effects. Resident 8		
					had no adverse effects from s	taff	
	b. At 9:39 a.m., LPN 2 was preparing Resident 84's				touching the rim and inside of		
	medications. LPN 2 picked up a medication cup to				medication cup and water cup		
	write the resident's room number on it. When he				Resident 58 had no adverse		
	did, he placed his index finger into the cup and				effects from staff touching the		
	pinched the cup between his index finger and				and inside of medication cup a		
	thumb to write on the cup. LPN 2 performed hand				water cup. Resident 20 had no		
	hygiene then touched the medication carts drawer				adverse effects from staff not		
	handle to pull out a medication pill card. When				maintaining a clean technique		
	dispensing the medications into the medication				during medication preparation		
	cup, LPN 2 would pop the pills from the pill card				Resident 84 had no adverse		
	into his hand and then dump the pill into the				effects from staff not maintaini	-	
	medication cup with each of the medications that				clean technique during medica		
	were to be given. LPN 2 repeated that procedure				preparation. Resident 58 had no		
	with Resident 84's aspirin, duloxetine (an				adverse effects from staff not		
	antidepressant and nerve pain medication), iron,				maintaining a clean technique		
	Gemtesa (treats overactive bladder), lisinopril (a				during medication preparation.		
	blood pressure medication), magnesium,			Resident 17 did not have any			
	pantoprazole (an acid reducer), and potassium.			adverse effects from staff not			
	Once all the pills were dispensed, LPN 2			cleaning insulin pens' rubber hub			
	performed hand hygiene and grabbed the cup of water by pinching the rim in between his index			prior to placing sterile needle.			
				Resident 72 did not have any			
	finger and thumb and, with the same hand, wedged the medication cup into the thumb part of				adverse effects from staff not		
		ire rim of the medication cup			cleaning insulin pens' rubber h		
	was in full contact	-			prior to placing sterile needle. residents had adverse effects		
	was in full contact	with the path area.					
					staff not following glove guidel	iries	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/S		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
			B. WING			07/25/2024	
				CTD FFT A	ADDRESS STEW STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
DOOFWALKATILITUEDWOODO					RITTER AVE		
RUSEWA	ALK AT LUTHERW	OODS		INDIAN	APOLIS, IN 46219		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDENCE NEAR OF CONDECTION			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	, L	DATE
	c. At 9:45 a.m., LP	N 2 went to prepare Resident			in the kitchen. LPN 2 provided		
		PN 2 performed hand hygiene,			reeducation on medication		
		edication cart drawer handle,			administration procedures and		
		x (seizure medication) tablet			skills validation completed. LPN 2		
		nen placed the tablet into the			provided reeducation on insulin		
		then opened a bottle of			administration procedures and		
	_	medication) and dug out one			skills validation completed. Co		
	· ·	er, cracked the tablet in half in			provided reeducation on glove		
	_	ne half of the tablet into the			in the kitchen, handwashing a		
	_	the other half back into the			glove use skills validation		
	•	hands. LPN 2 then placed the			completed by 8/23/24.		
	bottle back into the medication cart. LPN 2				What measures will be		
	popped Vitamin B12 and Vitamin D3 into his				put into place or what systemic		
	hands first then placed them in the medication				changes the facility will make		
	cup. When going to administer the medications to				to ensure that the deficient	-	
	Resident 58, LPN 2 grabbed the cup of water by				practice does not recur;		
	pinching the rim in between his index finger and				Inservice all staff on proper	alove	
	thumb and, with the same hand, wedged the				use and infection control.	,	
	medication cup into the thumb part of his hand so,				Medication pass audits on all		
	_	e medication cup was in full			qualified staff by 8/25/24.		
	contact with his pal	-			Handwashing skills validation	for	
	•				culinary staff. Pharmacy to do		
	2. An insulin admin	nistration observation with LPN			medication pass audit with		
	2 was conducted, or	n 7/24/24, in the diabetic clinic.			qualified staff.		
	a. At 11:00 a.m., LPN 2 was preparing the aspart insulin pen for Resident 17 when he took off the cap and immediately placed a sterile needle onto the pen. LPN 2 did not scrub the rubber seal on the pen with alcohol prior to placing the sterile				How the corrective		
					action(s) will be monitored to	)	
					ensure the deficient practice		
					will not recur, i.e., what quali		
					assurance program will be p	-	
					into place;		
	needle on the pen.			LPN 2 provided reeducation on		on	
	1		medication administration				
	b. At 11:07 a.m., LPN 2 was preparing a Humalog			procedures and skills validation			
	insulin pen for Resident 72. He took off the			completed. LPN 2 provided			
	insulin pen's cap and immediately placed a sterile			reeducation on insulin			
	needle onto the pen. LPN 2 did not scrub the				administration procedures and		
	rubber seal on the pen with alcohol prior to				skills validation completed. Cook 3		
	placing the sterile n				provided reeducation on glove		
		-			in the kitchen, handwashing a		
	An interview condu	acted with Director of Nursing			glove use skills validation		
					l ~		l

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AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			(X2) MULTII A. BUILDI B. WING		NSTRUCTION 00	(X3) DATE COMPL <b>07/25</b> /	ETED	
NAME OF PROVIDER OR SUPPLIER ROSEWALK AT LUTHERWOODS			STREET ADDRESS, CITY, STATE, ZIP COD 1301 N RITTER AVE INDIANAPOLIS, IN 46219					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		PREF	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
IAU	(DON), on 7/24/24 medication pills/tab handled with bare handled with bare handled with bare handled with bare handled, on 7/24/2 indicated the follow straight off. Do not the Rubber Seal with the R	at 1:28 p.m., indicated olets/capsules should not be hands.  Truse Humalog Kwik-pen 1:24 at 11:32 a.m., from the DON, wing, "Step 1: Pull the Pen Cap tremove the Pen Label. Wipe th an alcohol swab"  The paration and Medication icy was received, on 7/24/24 at icated the following, "Procedure ag to administer, assist or ake his/her medications, an appetent community staff flow the community staff flow the community staff should not on when opening a bottle or wation, on 7/23/24 at 11:35 a.m., a stack of 4 plates from the clean ach service with her ungloved ed her thumb in the middle of 3 then gloved her hands and eft hand on the corner of the mes while making one g bread, deli-meat, lettuce,		7	completed by 8/23/24. Culinar glove use QA tool used weekl and then monthly x3. Handwashing QA tool used weekly x4 and then monthly x Medication pass observation tool used weekly x4 and then monthly x3. If 90 percent threshold not met, then disciplinary action and new ac will be completed. DNS or ED/designee will complete monitoring tools.	y y x4 3. QA	DATE	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  07/25/2024		
			D. WII	_		07/25/2024		
NAME OF PROVIDER OR SUPPLIER ROSEWALK AT LUTHERWOODS			STREET ADDRESS, CITY, STATE, ZIP COD 1301 N RITTER AVE INDIANAPOLIS, IN 46219					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	Kitchen, dated 7/23, was provided by the ED on							
	7/25/24 at 10:15 a.m. The policy indicated the							
	following, "Culinary staff will wash handsbefore placing gloves on hands".							
	An Infection Control and Prevention policy received, on 7/24/24 at 10:51 a.m., from the ED indicated the following, "Policy: To guide the activities of the Infection Control and Prevention Programthe Community shall establish and Infection Control and Prevention Program to: investigate, control and prevent infection in the community; to determine appropriate procedure; and to maintain records of the Community's incidence and corrective actions."							

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