STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING 00 B. WING	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION ST LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Invesitigation of Complaints IN00433022, IN00434158, IN00434300, and IN00434621. Complaint IN00433022 - No deficiencies related to the allegations are cited. Complaint IN00434158 - No deficiencies related to the allegations are cited. Complaint IN00434300 - No deficiencies related to the allegations are cited. Complaint IN00434621 - No deficiencies related to the allegations are cited. Survey dates: May 21, 22, 23, 24, 28 and 29, 2024 Facility number: 000051 Provider number: 155121 AIM number: 100275490 Census Bed Type: SNF/NF: 104 Total: 104 Census Payor Type: Medicare: 3 Medicaid: 88 Other: 13 Total: 104 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on June 3, 2024.	F 0000	Rosewalk Village of Lafayette respectfully requests desk review for this deficiency.	
F 0684 SS=D	483.25 Quality of Care			

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

Nathan Anderson | Executive Director | 06/10/2024

Any defiencystatement 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 disclo days 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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Bldg. 00	§ 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to ensure insulin doses were held per physician's order, to notify the physician in a timely manner, and to follow the ordered hypoglycemic protocol for 1 of 2 residents reviewed for insulin. (Resident 5) Finding includes: The clinical record for Resident 5 was reviewed on 5/23/24 at 3:11 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus with hyperglycemia (high blood sugar), hypoglycemia (low blood sugar), diabetic neuropathy, diabetic retinopathy without ocular edema (eye disease), hypotension, Alzheimer's disease, and syncope and collapse. 1. A physician's order, dated 4/3/24 and discontinued 5/16/24, indicated to give 10 units of lispro insulin with meals with special instructions to hold the dose if the blood sugar was less than 110. A vital signs record indicated the following: a. On 5/11/24 at 8:59 a.m., the blood sugar was 109 mg/dL. b. On 5/14/24 at 7:24 a.m., the blood sugar was 83 mg/dL. c. On 5/14/24 at 11:55 a.m., the blood sugar was 95	F 0684	**F684- Quality of Care** It is the practice of this facility to ensure follow physician's orders and notify the physician in a timely manner. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The MD was immediately notified of Resident 5 blood sugars and MD review resident's insulin orders. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents receiving insulin have the potential to be affected by this finding. A facility audit will be completed by DNS/designee for all residents with insulin order to be sure that physicians are being notified and ordered followed for hypoglycemic protocol. All residents identified in this audit	06/26/2024

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	mg/dL. A diabetic medication administration record (MAR) indicated the following: a. On 5/11/24 at 7:00 a.m., 10 units of lispro insulin were given in the right arm with a recorded blood sugar of 109 by RN 2. b. On 5/14/24 at 9:50 a.m., 10 units of lispro insulin were given in the abdomen with a recorded blood sugar of 83 mg/dL by RN 3. c. On 5/14/24 at 1:46 p.m., 10 units of lispro insulin were given in the left arm with a recorded blood sugar of 95 mg/dL by RN 3. During an interview, on 5/28/24 at 2:41 p.m., the Assistant Director of Nursing (ADON) indicated the nurses would know when to hold a medication by looking at the hold order on the Medication Administration Record (MAR). 2. A physician's order, dated 4/3/24, indicated to check the blood sugar four times per day and to notify the physician if the blood sugar was below 60. A physician's order, dated 4/8/24, indicated a hypoglycemic protocol: if the blood glucose was 60 or below and the resident was able to consume intake then administer 4 ounces of juice and recheck the blood glucose in 15 minutes. A vital signs record indicated the following: a. On 5/15/24 at 7:41 p.m., the blood sugar was 56 mg/dL. b. On 5/17/24 at 10:00 p.m., the blood sugar was 58 mg/dL. The electronic medical record did not include a rechecked blood sugar for 5/17/24 at 10:00 p.m. A nursing progress note, dated 5/15/24 at 9:00		will be reviewed and ensure that hypoglycemic protocol is followed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The DNS/designee will in-service nurses on hypoglycemic protocol on or before 6/26/24. DNS/designee will conduct daily review of the facility activity report to ensure hypoglycemic protocol is followed. **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:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “MD Notification” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up **By what date the systemic changes will be completed:** Compliance Date: 6/26/24	

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	p.m., indicated the resident's bedtime blood sugar was 56. A message was left in the binder for the provider to review later. A nursing progress note, dated 5/19/24 at 11:06 p.m., indicated the previous shift nurse left another message in the binder due to hypoglycemia episodes over the weekend. During an interview, on 5/28/24 at 2:41 p.m., the ADON indicated the nurse should call the doctor for blood sugar readings below or above the parameters given in the orders, which were typically below 60 and above 450. The hypoglycemic protocol for low blood sugars under 60 was to give 4 ounces of juice if the resident was able to safely drink and then recheck the blood sugar in 15 minutes. During an interview, on 5/28/24 at 3:49 p.m., the Director of Nursing (DON) indicated the nurse should notify the Nurse Practitioner (NP) by writing the blood sugar on the non-urgent log for the provider to see the information while she rounded that day or on the next day. If the abnormal blood sugar happened on a weekend when the NP would not be coming in, then the nurse should call the on-call provider. The hypoglycemic protocol was to give 4 ounces of juice and to recheck the blood sugar in 15 minutes. Waiting over an hour for a recheck of the blood sugar was not following the protocol. A current policy, titled "Resident Change of Condition Policy," dated as revised on 11/2018 and received from the DON on 5/29/24 at 10:00 a.m., indicated "...All symptoms and unusual signs will be documented in the medical record and communicated to the attending physician promptly...."			

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	A current policy, titled "Blood Glucose Monitoring," dated as revised on 2/2015 and received from the DON on 5/29/24 at 10:15 a.m., indicated "...The physician will be notified when the resident's blood glucose is outside the physician stated parameters...Immediate treatment of hypoglycemia will be completed as follows... (resident) will receive 4 ounces of juice. Recheck blood glucose in 15 minutes and document...Blood glucose results will be documented on the Capillary Blood Glucose Monitoring Tool or on the medication administration record." 3.1-37(a)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the			

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	health care provider orders a therapeutic diet. Based on interview and record review, the facility failed to notify the physician about a significant weight loss in a timely manner for 1 of 5 residents reviewed for nutrition. (Resident 67) Finding includes: The clinical record for Resident 67 was reviewed on 5/23/24 at 11:53 a.m. The diagnoses included, but were not limited to, end stage renal disease, chronic diastolic (congestive) heart failure, acquired absence of left leg below the knee, hypertensive heart, chronic kidney disease with heart failure, and stage 5 chronic kidney disease. A current care plan, with a start date of 5/19/21, indicated to notify the medical doctor (MD)/family of significant weight changes. The weight log indicated the following weights: 7/5/23: 216 pounds 8/10/23: 197 pounds 8/16/23: 198 pounds 9/12/23: Not Taken (refused) 10/06/23: Not Taken (refused) 10/11/23: INVALID 10/13/23: 171 pounds 10/25/23: INVALID 10/27/23: 172 pounds An interdisciplinary team (IDT) progress note, dated 8/10/23, indicated the resident's weight was 197 lbs. The resident had a significant weight loss of 9% in 36 days. The root cause for the weight loss was because the resident had a left below the knee amputation (BKA). The physician was notified of the weight change. An IDT progress note, dated 10/23/23, indicated	F 0692	**F692 Nutrition/Hydration Status Maintenance** It is the practice of this facility to notify the physician about a significant weight loss in a timely manner. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The physician was immediately notified of Resident 67 weight loss **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents at risk for weight loss have the potential to be affected by this finding. A facility audit will be completed by DNS/designee for all residents with significant weight loss to ensure the physician was notified. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The DNS/designee will in-service nurses on MD Notification on or before 6/26/24. DNS/designee will conduct weekly review of resident weights to ensure the physician is notified of any significant weight loss. **How the corrective action(s)**	06/26/2024

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	the resident's current weight was 171 lbs. The resident had a weight loss of 14% in 158 days. The resident had a 13% weight loss from 8/16/23 to 10/13/23. The provider was not notified of the significant weight loss until 10 days later. During an interview, on 5/29/24 at 3:48 p.m., the Director of Nursing (DON) indicated they did not see notification to the physician until 10/23/24. A current policy, titled "Resident Weight Monitoring," dated as last reviewed on 7/2023 and received from the DON on 5/29/24 at 3:50 p.m., indicated "...The physician/health care provider will be notified of unplanned significant weight loss/gains...." 3.1-46(a)(1)		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “MD Notification” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up **By what date the systemic changes will be completed:** Compliance Date: 6/26/24	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and			

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	permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure over the counter (OTC) medications were labeled with the directions for use and the physician's name for 1 of 3 medications carts reviewed for medication storage. (Cart 100) Finding includes: During an observation of medication storage, on 5/21/24 at 12:22 p.m., with LPN 2 the medication cart 100 on the dementia unit had the following: a. One bottle of OTC aspirin 81 milligram (mg) with the name of Resident 104 handwritten in black. There was no label, no instructions for use of the medication, and no physician's name on the bottle. The bottle was not opened. b. One opened bottle of OTC aspirin 81 mg with 365 tables with the name of Resident 104 handwritten in black. There was no label, no instructions for use of the medication, and no physician's name on the bottle. c. One bottle of OTC turmeric 500 mg capsules for Resident 104. There was no label, no instructions for use of the medication, and no physician's name on the bottle.	F 0761	**F761 Label/Storage Drugs and Biologicals** It is the practice of this facility to label drugs and biologicals used in the facility in accordance with currently accepted professional principles. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** All incorrectly labeled, dated, expired medications were disposed of in accordance with the pharmacy policies. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. A facility audit will be completed by DNS/designee for all medication storage areas to ensure all	06/26/2024

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	d. One bottle of OTC chewable aspirin tablets 81 mg with the name of Resident 87 handwritten in black. There was no label, no instructions for use, and no physician's name on the bottle. e. One bottle of OTC allergy relief cetirizine 10 mg with the name of Resident 87 handwritten in black. There was no label, no instructions for use, and no physician's name on the bottle. The clinical record for Resident 104 was reviewed on 5/21/24 at 3:05 p.m. The diagnoses included, but were not limited to, dementia and insomnia. A physician's order for Resident 104, dated 3/26/24 and open ended, indicated to give aspirin 81 mg once a day. A physician's order for Resident 104, dated 4/27/24 and open ended, indicated to give turmeric root extract 500 mg capsule once a day. The clinical record for Resident 87 was reviewed on 5/21/24 at 3:20 p.m. The diagnoses included, but were not limited to, dementia, low back pain, and heart disease. A physician's order for Resident 87, dated 2/26/24, indicated to give a chewable aspirin 81 mg once a day. A physician's order for Resident 87, dated 5/10/24, indicated to give cetirizine 10 mg at bedtime. During an interview, on 5/21/24 at 3:00 p.m., the Director of Nursing (DON) indicated the policy for medication labeling indicated "according to regulations". The DON was not able to say what the regulations were for labeling OTC medications.		medications are labeled correctly. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The DNS/designee will in-service nurses on Medication Labeling on or before 6/26/24. DNS/designee will conduct daily rounds to ensure medications are labeled correctly. **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:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Medication Labeling” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up **By what date the systemic changes will be completed:** Compliance Date: 6/26/24	

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	During an interview, on 5/22/24 at 3:55 p.m., the facility pharmacist indicated she would need to look up the professional standards for labeling OTC medications in a long-term care facility. An email dated 5/22/24 at 4:16 p.m., from the facility pharmacist indicated the OTC medications would need to be identified with the resident's name, the physician's name, the expiration date, the name of the drug and the strength. A current policy, titled "Storage and Expiration of Medications, Biologicals, Syringes and Needles," dated as revised on 1/13/23 and received from the DON on 5/21/24 at 3:01 p.m., indicated "...Facility should ensure that medications and biologicals...Have an Expiration Date on the label...Facility should request that Pharmacy perform a routine nursing unit inspection for each nursing station in Facility to assist Facility in complying with its obligations pursuant to Applicable Law relating to the proper storage, labeling, security and accountability of medications and biologicals...." 3.1-25(j) 3.1-25(k)(1) 3.1-25(k)(2) 3.1-25(k)(5)			