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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosewalk Village at Lafayette	1903 Union St Lafayette, IN 47904

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 49891 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 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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 48525 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 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. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 36454 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. 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. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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)