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	03/03/2026

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview and record review, the facility failed to ensure a resident was assessed to self-administer medications for 1 of 1 resident randomly reviewed for self-medication administration. (Resident 109) Findings include:During an observation, on 2/24/26 at 12:41 p.m., a clear plastic medicine cup, containing a white oblong pill, was observed on Resident 109's bedside table.During an observation and interview, on 2/24/26 at 12:55 p.m., the Director of Nursing (DON) entered Resident 109's room and removed the cup with the pill in it from the bedside table. The DON indicated the cup with the pill should not have been left at the bedside table.The clinical record for Resident 109 was reviewed on 2/26/26 at 10:35 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic neuropathy, chronic pain, pain in the left and right knee, abnormal posture, and muscle weakness.A physician's order, dated 9/16/25, indicated to administer hydrocodone-acetaminophen 7.5/325 milligrams every four hours.A care plan, dated 1/28/26, indicated the resident had chronic pain and bilateral knee pain. Interventions included, but were not limited to, administer medications as ordered.The clinical record did not contain a physician's order, a self-medication administration assessment, or a care plan for Resident 109 to self-administer medications.During an interview, on 3/3/26 at 10:09 a.m., the Assistant Director of Nursing (ADON) indicated Resident 109 did not have a physician's order to self-administer medications. The medication cup with the pill in it should not have been left in the room on the bedside table.During an interview, on 3/3/26 at 10:15 a.m., Registered Nurse (RN) 4 indicated the staff administering the medication must stay in the room and observe all medications were taken by the resident. If medications were left at bedside, the resident must have an order.During an interview, on 3/3/26 at 10:16 a.m., the DON indicated Resident 109 did not have an order to self-administer medications and the cup with the pill should not have been left in the room on the bedside table.During an interview, on 3/3/26 10:26 a.m., RN 3 indicated staff must observe a resident taking all medications before walking away from the resident. Medicine should not be left at bedside.During an interview, on 3/3/26 10:28 a.m., RN 5 indicated medications should not be left at bedside and staff should watch the residents take the medication.A current facility policy, titled General Dose Preparation and Medication Administration, dated as last revised November 2024 and received from the ED on 3/3/26 at 9:37 a.m., indicated .During medication administration, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following.Observe the resident's consumption of the medication(s).A current facility policy, titled Self-Administration of Medications, dated as last revised January 2015 and received from the ED on 3/3/26 at 10:19 a.m., indicated .A physician order will be obtained specifying the resident's ability to self-administer medications and, if necessary, listing which medications will be included in the self-administration plan. 410 IAC (Indiana Administrative Code) 16.2-3.1-11(a)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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. Based on interview and record review, the facility failed to ensure a physician's order to hold medications was followed according to the parameters for 1 of 3 residents reviewed for quality of care. (Resident 29)Findings include:The clinical record for Resident 29 was reviewed on 2/26/26 at 11:59 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, vascular dementia with psychotic disturbance, psychotic disorder with delusions, adjustment disorder with anxiety, muscle weakness, and hypotension.A care plan, dated 8/7/25, indicated Resident 29 was at risk for fluid imbalance due to blood pressure issues. Interventions included, but were not limited to, administer medications as ordered.A physician's order, dated 9/13/25, indicated to administer 5 milligrams (mg) of midodrine (a medication used to treat low blood pressure) every morning and to hold the medication for a systolic blood pressure (SBP) greater than 130.The Medication Administration Record (MAR), dated 12/1/25 through 12/31/25, indicated midodrine was administered outside of the hold parameters on 12/13/25, with a systolic blood pressure of 155, and on 12/16/25 with a systolic blood pressure of 135.The MAR, dated 1/1/26 through 1/31/26, indicated midodrine was administered outside of the hold parameters on 1/8/26, with a systolic blood pressure of 138, and on 1/30/26 with a systolic blood pressure of 137.The MAR, dated 2/1/26 through 2/26/26, indicated midodrine was administered outside of the hold parameters on 2/22/26, with a systolic blood pressure of 153.During an interview, on 3/3/26 at 11:13 a.m., Licensed Practical Nurse (LPN) 2 indicated if a medication was due and the blood pressure was outside of the parameters, the medication would be held and the doctor notified if needed. If a medication was held, the nurse's initials would be in parenthesis on the MAR to indicate it was held.During an interview, on 3/3/26 at 11:21 a.m., the Director of Nursing (DON) indicated a medication should not be administered outside of the hold parameters.During an interview, on 3/3/26 at 11:54 p.m., the Assistant Director of Nursing (ADON) indicated the facility did not have a policy specifically about medication parameters.A current facility policy, titled General Dose Preparation and Medication Administration, dated 12/1/07 and received by the Executive Director on 3/3/26 at 9:37 a.m., indicated .Prior to administration of medication, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following.if necessary, obtain vital signs.410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)