

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155329	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  Rosewalk Village		STREET ADDRESS, CITY, STATE, ZIP CODE  1302 N Lesley Ave Indianapolis, IN 46219	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>34850</p> <p>Based on interview and record review, the facility failed to ensure residents' dignity was respected for 3 of 4 residents reviewed for abuse. (Residents' J, K, and L)</p> <p>Findings include:</p> <p>1. The clinical record for Resident K was reviewed on 3/10/25 at 10:00 a.m. The diagnoses included, but were not limited to, heart disease.</p> <p>A Quarterly Minimum Data Set (MDS) assessment, dated 1/8/25, indicated Resident K was cognitively intact.</p> <p>An interview was conducted with Resident K on 3/10/25 at 10:09 a.m. She indicated she had reported Licensed Practical Nurse (LPN) 22 to the Executive Director (ED). He was always hateful and rude towards her. LPN 22 was changing her humidifier for her oxygen, and during that time, the interaction between LPN 22 and Resident K was not respectful. LPN 22 had made rude statements to her and stuck up his middle finger. She had stated to him, you're not my daddy, and he responded, you're not my mama. She expected LPN 22 to apologize to Resident K for being treated that way, but she had not received an apology. LPN 22 no longer worked at the facility.</p> <p>A reportable incident to the Indiana Department of Health with an investigation file was provided, on 3/10/25 at 3:38 p.m., from the ED. The incident report, dated 2/4/25, indicated Resident K had reported customer care concerns with a staff member (LPN 22) on 2/3/25. The follow up completed indicated the other staff person, Certified Nurse Aide (CNA) 6, had been in the resident's room at the time of the incident and did not witness LPN 22 being rude to Resident K. The investigation file of the incident between LPN 22 and Resident K included, but was not limited to, the following documents:</p> <p>An e-mailed statement by CNA 6, dated 2/6/25, indicating she had asked LPN 22 to assist her with Resident K's roommate. During that time, she observed LPN 22 and Resident K bickering back-and-forth with each other. She did not hear any cussing during the interaction between LPN 22 and Resident K. She did hear Resident K request for LPN 22 not to speak to her. LPN 22's response was Okay. You don't want to talk to me. After, CNA 6 had exited the room first with LPN 22 coming from behind, so she had not observed LPN 22 sticking up his middle finger at Resident K prior to exiting the room.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A typed statement by LPN 22, dated 2/3/25, indicated on 2/3/25 at approximately 5:00 a.m., he was in Resident K's room preparing to change out oxygen tubing and condenser water for Resident K. The resident, he believed, had gotten upset because she had been woken up while changing the oxygen supplies. The resident had declined for staff to change out her oxygen supplies at that time. LPN 22 had explained the oxygen items needed to be changed and exchange the old ones with new ones. CNA 6 provided care to Resident K's roommate and requested his assistance. During that time, Resident K was shouting random negative comments like you're not my dad so you can't tell me when to change anything. As LPN 22 was helping CNA 6, Resident K would say something negative towards LPN 22 about every two to three minutes, or so, with no reaction from LPN 22. LPN 22 and CNA 6 finished up with the roommate and as they both were walking out of the room and LPN 22 was pulling the door closed, Resident K yelled out she was going to tell everyone and today was LPN 22's last day.</p> <p>Typed resident statements were included in the investigation file. It indicated the following statements from Resident L and Resident J:</p> <p>Resident L was asked, Did nurse [LPN 22] ever cuss at you or made you feel upset? Resident L responded, When I'd [sic] didn't do what he wanted one day, we got into an argument, he was like, man F*** you. So, I told him, F*** you back.</p> <p>Resident J was asked, Did nurse [LPN 22] ever cuss at you or made you feel upset? Resident J responded, He is pushy and rude. Always trying to make me take stuff I don't want to take too forceful for me.</p> <p>2. The clinical record for Resident J was reviewed on 3/10/25 at 12:00 p.m. The diagnoses included, but were not limited to, heart failure.</p> <p>A Significant Change MDS assessment, dated 1/14/25, indicated Resident J was cognitively intact.</p> <p>An interview was conducted with Resident J on 3/11/25 at 12:13 p.m. He indicated LPN 22 was pushy and demanding. He would wake him up in the middle of night and want him to do something. For example, Take a sip of water. If he declined, LPN 22 would not take no for an answer. Resident J had requested he did not want LPN 22 back in his room anymore due to being disrespectful.</p> <p>3. The clinical record for Resident L was reviewed on 3/10/25 at 1:00 p.m. The diagnoses included, but were not limited to, quadriplegia.</p> <p>A Quarterly MDS assessment, dated 1/30/25, indicated Resident L was cognitively intact.</p> <p>An interview was conducted with Resident L on 3/11/25 at 2:19 p.m. He indicated he did have an argument with LPN 22 a while back. He rushes through care and doesn't listen. During an argument with LPN 22, he had stated to Resident L, shut the f*** up, and he responded, with repeating the same words he said back to him. The nurse just didn't want to listen to what he had to say. He had spoken to the Director of Nursing (DON) and the ED about the incident. LPN 22 was disrespectful. It was addressed and over now. It did not happen again.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with the ED on 3/13/25 at 9:49 a.m. He indicated he had completed the investigation into the reportable incident between Resident K and LPN 22. During the investigation, he had also spoken to Resident L and Resident J. A discussion with LPN 22 was provided and included education about his mannerisms. LPN 22 had stated to the ED he was just trying to coach the residents to have a better life and encourage them to be healthier. LPN 22 meant well, but he was disrespectful. LPN 22 has been on medical leave since the incident.</p> <p>A resident's rights policy was provided by the DON on 3/13/25 at 1:59 p.m. It indicated, .In accordance with this right to dignity and respect, residents are entitled to all of the freedom and privileges of any other citizen. The resident also has obligations and responsibilities to the Community staff and other residents .Every resident in a long-term care facility shall have at least the following rights . (18) Each resident shall be treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs .</p> <p>This citation relates to complaint IN00451232.</p> <p>3.1-3(t)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>52119</p> <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on observation, interview, and record review, the facility failed to get residents up to a wheelchair and complete regular hair shampooing for 1 of 4 residents reviewed for ADLs (Activities of Daily Living). (Resident G)</p> <p>Findings include:</p> <p>The clinical record for Resident G was reviewed on 3/11/25 at 10:00 a.m. The diagnoses included, but were not limited to, anemia, cancer, heart failure, diabetes, hemiplegia caused by stroke (weakness on one side of the body), and depression.</p> <p>A Quarterly Minimum Data Set assessment, completed 12/20/24, indicated Resident G's preferred language was Spanish, and she needed an interpreter to communicate with doctors or health staff. It also indicated Resident G was cognitively intact with impairment of her right upper extremity.</p> <p>On 3/12/25 at 9:39 a.m., Resident G was observed in her room, lying in bed wearing a hospital gown. The resident's hair was oily, stringy, and tangled in the back. She indicated she had not had a shower, a full bed bath, or her hair shampooed in about 10-12 days. She asked the staff to wash her hair, but they did not. The staff had not gotten her up to her wheelchair in a long time. She used to have a wheelchair in her room, but she had not seen it for many days. No wheelchair was observed in the room. She indicated she would like to get up to a wheelchair. She does remember the staff using a machine to get her up, but she has not seen the machine in a long time.</p> <p>During an interview on 3/12/25 at 11:46 a.m. with Licensed Practical Nurse (LPN) 10, she indicated the resident's showers were scheduled for Tuesdays and Fridays. While the resident does not frequently refuse care, she has been known to in the past. She could communicate well with Resident G, who makes her needs known well enough. The resident was a Hoyer lift with a two people assist to transfer and said there should be a wheelchair in the resident's room. The Assistant Director of Nursing Services (ADNS), who attended the interview, indicated the resident does have a wheelchair, but she does not know where it was. The resident had told them she likes to stay in a hospital gown and stay in bed.</p> <p>During an interview with Certified Nurse Aide (CNA) 9 on 3/12/25 at 1:55 p.m., she indicated she gave the resident a partial bed bath the day prior (3/11/25) because the resident requested a partial bed bath instead of a full one.</p> <p>During an observation and interview with Resident G on 3/13/25 at 9:53 a.m., she indicated she had not yet received a complete bed bath or shower this week, and her hair had still not been washed. Resident G's hair was very oily, stringy, matted, and now had some flakes of skin near her scalp. She indicated a wheelchair was now in her room, and it was the first time she had seen one in many days. She would like to get up to the wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Director of Nursing (DON) provided shower sheets, on 3/13/25 at 10:48 a.m., which covered the period from 2/4/25 to 3/11/25. According to the shower sheet for 3/11/25, the CNA documented she had given the resident a complete bed bath and shampooed the resident's hair. Prior to the 3/11/25 documentation, the last time staff documented washing the resident's hair was on 2/25/25.</p> <p>During an interview with the Occupational Therapist (OT) on 3/13/25 at 9:11 a.m., she indicated she did a new evaluation with the resident, on 3/12/25, after the Speech Therapist (ST) referred the resident to her for evaluation for a wheelchair. The ST wanted the resident to be up in a wheelchair in the dining room for meals. She thought she had an 18-inch wheelchair but needed a larger one. The resident's wheelchair was not available when she did her evaluation, and she could not speak to what nursing had been doing to get the patient out of bed. The resident had a decline in bed mobility since she was last seen a year ago, had right arm hemiparesis (weakness), increased left arm weakness, and needed a different wheelchair. She communicated well with the resident using gestures and the resident understood more English than she speaks. She indicated the resident did seem receptive to using the wheelchair and she will be working on getting a larger wheelchair for the resident.</p> <p>During an interview with the ST on 3/13/25 at 9:24 a.m., she indicated she evaluated Resident G, on 3/4/25, to assess swallowing due to the resident's emergency oral surgery. She wanted to make sure the resident was on an appropriate diet. She indicated Resident G did not want to try a puree diet and wanted to stay on a regular diet. She wants her up in a wheelchair in the dining room for meals, just to get her out of her room.</p> <p>During an interview with the Therapy Manager on 3/13/25 at 9:30 a.m., she indicated when Resident G first admitted , she was using an 18-inch wheelchair, but therapy then put her in a 20-inch wheelchair, and that should be utilized by nursing staff currently.</p> <p>During an interview with the DON on 3/13/25 at 10:48 a.m., she indicated the ADNS had found the resident's wheelchair and put it in the room that morning. The wheelchair may not have been in the resident's room this week if it had been taken to be cleaned. She indicated the night shift CNAs have assigned room wheelchairs to wash on different days of the week. They take the wheelchair to the shower room, wash it, then line them up in the gym to dry overnight. They bring them back in the morning once they are dry, but if they forget, the day shift will come get them. Otherwise, the wheelchair stays in the resident's room when not being cleaned. She indicated this morning, the resident asked LPN 10 if she could get up to her wheelchair. However, when the DON came in later to assist, the resident told her she did not want to get up. Resident G was observed shaking her head no while the DON made this statement.</p> <p>A care plan for ADLs, dated 4/12/24, indicated Resident G required assistance with ADLs related to impaired mobility and the history of a cerebrovascular accident (stroke). Her ability to participate in ADL care fluctuated from the morning to evening, and day to day. The goal was for Resident G to have their needs met daily with staff assistance as evidenced by being neat, clean, well-groomed, and dressed appropriately. Resident G was a two-staff person assisting with the use of a Hoyer (mechanical) lift and assistance with bathing as needed per the resident's preference. The approach was to offer showers twice a week with a partial bed bath in between. A care plan approach, added 3/12/25, indicated Resident G preferred to stay in bed most of the time.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A care plan, dated 5/7/24, indicated the resident had impaired mobility related to right side body weakness. The care plan approaches included, Encourage resident to participate in transfer and bed mobility activities . Notify therapy of declines in mobility or improvement in mobility.</p> <p>A physician order, initiated on 5/24/24, indicated the resident was to have a Hoyer (a mechanical device that helps move people with limited mobility) and two people assist with transfers to bed and wheelchair. Another order, initiated on 10/16/24, indicated that a foam cushion should be on the seat of the resident's wheelchair.</p> <p>A care plan, dated 6/10/24, indicated Resident G Refuses ADL care at times. The care plan approach was to Educate resident on the possible negative effects from refusing ADL care at times.</p> <p>During an interview with the DON on 3/13/25 at 1:05 p.m., she indicated they do not have a policy on ADLs, and that they just follow standards of care.</p> <p>This citation relates to Complaint IN00453820.</p> <p>3.1-38(a)(2)(A)</p> <p>3.1-38(a)(2)(B)</p> <p>3.1-38(a)(3)(B)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>36942</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident with contractures (abnormal shortening or tightening of muscle tissue the renders the muscle highly resistant to stretching and can lead to permanent disability) received splint application as recommended by therapy staff for 1 of 2 residents reviewed for rehabilitation services. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 3/11/25 at 10:25 a.m. The diagnoses included, but were not limited to, hemiplegia (one-sided paralysis) and hemiparesis (one-sided muscle weakness) following cerebral infarction (stroke) affecting left non-dominant side, contracture of left wrist, contracture of left knee, contracture of left hand (fingers), contracture of left elbow, and muscle wasting and atrophy.</p> <p>An Admission Minimum Data Set (MDS) assessment, dated 1/10/25, indicated Resident B was cognitively intact, had impairment on one side of the upper and lower extremity, substantial assistance with upper body dressing, and dependent for lower body dressing.</p> <p>An activities of daily living (ADL) care plan, initiated on 1/4/25 and revised on 1/16/25, indicated Resident B required assistance with ADLs related to weakness and impaired mobility due to contractures to the left wrist, left knee, left fingers, and left elbow. The approach included physical and occupational therapy as ordered/indicated but no utilization of a splint.</p> <p>A physical therapy note, dated 1/24/25, indicated restorative nursing program set up and training for bilateral lower extremity and range of motion exercises. Restorative nursing aide demonstrated good understanding of the program.</p> <p>An occupational therapy note, dated 2/2/25, indicated the resident will safely wear a grip hand splint and an elbow extension splint on the left elbow for up to four hours with minimal signs of redness, swelling, discomfort or pain to prevent progression of contractures.</p> <p>An interview conducted with Therapy Manager, on 3/10/25 at 10:45 a.m., indicated Resident B had contractures and was receiving therapy services. Resident B fired all the therapy staff but was agreeable to receive the application of a splint, and such was done by nursing staff. The therapy staff conducted an in-service with all the nursing staff to ensure proper application of the splints.</p> <p>The clinical record for Resident B, reviewed on 3/11/25 at 10:27 a.m., did not include any physician orders for the application of splints. The clinical record for Resident B did not include any care plan related to the application of splints.</p> <p>An observation and interview conducted with Resident B, on 3/10/25 at 11:45 a.m., indicated no splint was observed to the left hand. Resident B indicated he should have a splint for his left hand, but the staff never apply the splint.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation and interview conducted with Resident B, on 3/11/25 at 3:39 p.m., indicated no splint was observed to the left hand.</p> <p>A policy entitled Restorative Nursing Program, revised 11/2018, was provided by the Director of Nursing on 3/11/25 at 2:08 p.m. The policy indicated the restorative nursing programs include active or passive range of motion and splint or brace assistance. The process of the program was coordinated, supervised and carried out by nursing staff. A resident-centered care plan will be developed by the nurse and include measurable objectives, specific interventions to maintain or improve function, or to prevent, to the extent possible, further declines in resident function.</p> <p>This citation relates to Complaint IN00452635.</p> <p>3.1-42(a)(2)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>40287</p> <p>Based on observation, interview, and record review, the facility failed to hold insulin when a blood sugar was below the physician's prescribed perimeters for 1 of 1 randomly observed insulin administration (Resident 20).</p> <p>Findings include:</p> <p>The clinical record for Resident 20 was reviewed on 3/9/25 at 11:31 a.m. The diagnoses included, but were not limited to, diabetes.</p> <p>A care plan, dated 10/21/24, indicated she was at risk for adverse effects of hyperglycemia (high blood sugar), or hypoglycemia (low blood sugar) related to use of glucose lowering medication and diagnosis of diabetes. The goal was for her not to experience symptoms of hyperglycemia or hypoglycemia. The interventions included monitoring blood sugar and administer medications as ordered.</p> <p>A physician's order, dated 12/30/24, indicated she was to receive insulin lispro (fast acting insulin) 12 units three times a day with meals; hold if blood sugar was less than 150 milligrams per deciliter (mg/dL).</p> <p>On 3/9/25 at 11:31 a.m., Licensed Practical Nurse (LPN) 25 was randomly observed administering medications to Resident 20. LPN 25 performed a blood sugar check on Resident 20 with a reading of 122. She went to the medication cart and opened a new lispro insulin pen. She primed the pen with two units of insulin, looked at the Medication Administration Record to check the lispro insulin order, and then set the insulin pen to administer 12 units of insulin lispro. LPN 25 gathered her supplies and entered Resident 20's room. LPN 25 asked Resident 20 where she wanted to receive her insulin and Resident 20 indicated she would like the insulin shot in her left arm. LPN 25 cleansed an area on Resident 20's upper left arm with alcohol and was preparing to administer 12 units of lispro insulin to Resident 20. The insulin administration was stopped.</p> <p>During an interview on 3/9/25 at 11:55 a.m., LPN 25 indicated the physician's order for Resident 20 included to hold the lispro insulin if her blood sugar was less than 150. LPN 25 indicated Resident 20's insulin lispro, 12 units, should have been held and not given.</p> <p>On 3/12/25 at 11:00 a.m., the Clinical Nurse Consultant (CNC) provided the Medication Administration Skills Competency, last revised July 2023, which read .Perform the 5 rights of medications: Right Resident, Right Time, Right Dose, Right Route, Right Time .</p> <p>3.1-48(c)(2)</p>		