STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. Building B. Wing	11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosewalk Village	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident with a diagnosis of dementia who was at risk of elopement did not exit the facility unsupervised for 1 of 3 residents reviewed for accidents. (Resident B) Resident B was found in the community, had fallen, and was transported to the hospital for treatment.The immediate jeopardy began, on 10/28/25, when Resident B exited the facility unsupervised and without the staff's knowledge while wearing a wanderguard device (a wearable device used to alert staff when a resident approached restrictive areas/doors). The resident was located approximately 0.6 miles away from the facility. The resident was found lying face down on the ground by a concerned citizen. The resident was transported to the hospital and had sustained a laceration and hematoma to his forehead, preorbital edema (swelling around his eye), an abrasion to his left knee and shoulder, and skin tears to the 4th and 5th digit on his left hand. The Executive Director, Director of Nursing, and Regional Director of Clinical Operations were notified of the immediate jeopardy on 11/12/25 at 3:09 p.m. The immediate jeopardy was removed, and the deficient practice corrected on 10/31/25, prior to the start of the survey and was therefore past noncompliance.Findings include:The clinical record for Resident B was reviewed on 11/10/25 at 10:22 a.m. The diagnoses included, but were not limited to, vascular dementia, Alzheimer's dementia, and hypertension.A physician's order, dated 7/23/24, indicated to check the wanderguard device for placement every shift and for functioning once a day.A care plan, dated 7/23/24, indicated Resident B was at risk for elopement and had a wanderguard device. The interventions, initiated on 7/23/24, included, but were not limited to, the facility exits were to be secured and a wanderguard device was placed to his right lower extremity.A care plan, dated 11/1/24, indicated Resident B was an intrusive wanderer at times. He presented with increased confusion and had a diagnosis of Alzheimer's/vascular dementia. The resident's goal was that the resident would remain safe in the facility, and he would be free of exit seeking behavior. A quarterly Minimum Data Set (MDS) assessment, dated 10/14/25, indicated wander/elopement alarms were used daily and Resident B was severely cognitively impaired.An elopement assessment, dated 10/14/25, indicated the resident was at risk for elopement.A nursing facility progress note, dated 10/14/25, indicated Resident B had asked staff to let him out of the door.The electronic health record or facility progress notes did not indicate what time the facility noticed the resident was missing, when the code silver was called, or when staff began to search for the resident. A hospital document indicated Resident B arrived at the emergency room on [DATE] at 7:32 p.m. The admission note indicated according to the EMS run sheet the patient stated he felt dizzy all the sudden and fell face first. The patient was unsure if he lost consciousness. Small lacerations were found on the patient's face. The patient was unable to explain why he was multiple miles away from his living facility. He reported he was running away from a dog and fell.The hospital records indicated the injuries documented were a wound on the right forehead, abrasions to the left forehead and left knee, a left shoulder and hand abrasion, a left forehead laceration, a left scalp laceration with surrounding swelling and oozing blood, and evidence of a subgleal hematoma (bleeding in the space between the skull and the skin on the scalp).A nursing facility progress note, dated 10/29/25 at 5:57 p.m., indicated the resident was assessed upon his return from the hospital. He was found to have the following skin issues; a laceration from eye/left forehead, a bruised left eye with decreased periorbital edema, a skin tear to the left pinky and the 4th digit on left hand and an abrasion to the left shoulder.There were no progress notes in the electronic health record to indicate the resident had any of the documented skin issues prior to the elopement, on 10/28/25.There were no facility nursing progress notes documented from 10/14/25 until the resident returned from the emergency room on [DATE].During an observation, on 11/10/25 at 9:50 a.m., Resident B was on the locked memory care unit and was observed to have a healing abrasion to his left shoulder.During an interview, on 11/10/25 at 11:29 a.m., the Director of Nursing (DON) indicated Resident B left the facility and was found by someone who called 911. The resident was picked up by emergency medical services (EMS) and taken to the emergency room. The facility knew Resident B exited the facility through the G-hall exit door because there was video footage. She indicated the resident was found one block away on Arlington Avenue.During an observation, on 11/10/25 at 1:47 p.m., the Executive Director (ED) started a video from the facility cameras. The video started at 6:00 p.m., on 10/28/25. The camera faced the G-hall. Resident B was seen walking slowly down the G-hall at 6:04 p.m. The angle of the camera did not show the exit door at the end of the hall. On the video, a dark shadow could be seen at the end of the hall. The shadow became light and then