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	03/06/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to ensure staff were implementing the care plan with monitoring and documenting outputs for 1 of 1 resident reviewed for implementation of care plans. (Resident 3) Findings include:The clinical record for Resident 3 was reviewed on 3/2/26 at 11:30 a.m. The diagnosis included, but was not limited to: stroke with left side hemiplegia (loss of function/movement). An a.m. and p.m. assistance and monitoring of Activities of Daily Living care plan, dated 11/9/25, indicated the resident required assistance with elimination. One of the interventions on the care plan included staff documenting the residents urine and bowel outputs every shift. A toileting program care plan, dated 11/14/25, indicated Resident 3 was to be toileted by staff every shift; before and after meal service, upon rising and nightly checks. Resident 3's February 2026 and March 2026 output reports indicated the following days and shifts there were no recorded urine outputs: -On 2/1/26, no output was documented for the resident on day and evening shift,-On 2/2/26 through 2/6/26, no output was documented for the resident on each day all shifts,-On 2/7/26 through 2/9/26, no output was documented for the resident on each day and evening shifts,-On 2/10/26 through 2/13/26, no output was documented for the resident on each day all shifts,-On 2/14/26 through 2/16/26, no output was documented for the resident on each day and evening shifts,-On 2/17/26, no output was documented for the resident on all shifts,-On 2/18/26, no output was documented for the resident on night and evening shift,-On 2/19/26 through 2/21/26, no output was documented for the resident on day and evening shifts,-On 2/28/26, no output was documented for the resident on day and evening shift, and-On 3/1/25 through 3/3/26, no output was documented for the resident on all shifts An interview was conducted with the Director of Nursing (DON) on 3/4/26 at 1:10 p.m. She indicated the staff should be monitoring and recording Resident 3's urine and bowel outputs every shift. A care plan policy was provided by the DON on 3/6/26 at 11:15 a.m. It indicated, Policy: It is the policy of this facility that each resident will have an interdisciplinary comprehensive person-centered care plan developed and implemented based on Resident Assessment Instrument (RAI) process. The care plan must include measurable goals and resident specific interventions based on resident needs and preferences to promote the resident's highest level of functioning. 410 IAC (Indiana Administrative Code) 16.3.1-35(d)(1)

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to timely conduct interdisciplinary care plan meetings for 2 of 2 residents reviewed for hospice and 1 of 2 residents reviewed for care planning (Residents 4, 6, and 9).Findings include: 1 The clinical record for Resident 4 was reviewed on 3/2/26 at 11:24 a.m. The resident's diagnoses included, but were not limited to, diabetes and dementia (mental decline). A Quarterly Minimum Data Set (MDS) Assessment, completed 2/4/26, indicated the resident had severely impaired cognition and received hospice services. Resident 4's clinical record contained a Care Plan Summary observation note, dated 2/4/26, that was not completed. The clinical record did not contain information that an Interdisciplinary Care Plan Meeting had been held after the completion on the Quarterly MDS Assessment. 2. The clinical record for Resident 9 was reviewed on 3/3/26 at 10:15 a.m. The resident's diagnoses included, but were not limited to, stroke (when blood flow to part of the brain was interrupted leading to lasting disability) and diabetes. The resident's clinical record contained a Care Plan Summary observation note, dated 2/11/26. The description indicated schedule care plan with hospice and family. The remainder of the observation note was not completed. A Significant Change of Status Minimum Data Set (MDS) Assessment, completed 2/18/26, indicated the resident had severely impaired cognition and was receiving hospice services. 3. The clinical record for Resident 6 was reviewed on 3/3/26 at 9:39 a.m. The resident's diagnoses included, but were not limited to, depression and diabetes. The resident's clinical record contained a Care Plan Summary observation note, dated 1/19/26. The description indicated a Quarterly care plan scheduled. A Quarterly MDS Assessment, completed 1/20/26, indicated the resident was cognitively intact. During an interview on 3/3/26 at 9:39 a.m., Resident 6 indicated he had not attended a care plan meeting. During an interview on 3/06/26 at 11:37 a.m., the Social Service Director (SSD) indicated there had not been interdisciplinary care plan meetings held for Resident 4, 9, and 6. The Interdisciplinary Care Plan Meetings should be held for each resident after an MDS Assessment was completed. On 3/6/26 at 10:29 a.m., the Director of Nursing Services provided the IDT Comprehensive Care Plan Policy, last reviewed October 2025, that read .Care plan review will be interdisciplinary and should include, to the extent possible, nursing, social services, activities, dietary, therapy, pharmacy, physician, direct care staff, and hospice personnel [if indicated]. Resident, resident's representative, or others as designated by resident will be invited to care plan review .Care plan problems, goals, and interventions must be reviewed and revised by the interdisciplinary team periodically and following completion of each OBRA[sic] MDS assessment . 410 IAC (Indiana Administrative Code) 16.3.1-35(e)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident received vision services for 1 of 1 residents reviewed for vision services. (Resident 50) Findings include: The clinical record for Resident 50 was reviewed on 3/2/26 at 11:30 a.m. The diagnosis included, but was not limited to, stroke (when blood flow to the brain was interrupted causing cells to die lead to lasting disability). The resident was admitted on [DATE]. A quarterly 1/14/26 Minimum Data Set (MDS) Assessment indicated Resident 50 was moderately cognitively impaired. A vision care plan, dated 10/4/23, indicated Resident 50's vision was impaired. The resident wore eye glasses. The staff were to arrange for eye doctor visits as needed. An ancillary consent, dated 10/6/23, indicated Resident 50 did want eye care. An interview was conducted with Resident 50 on 3/2/26 at 2:34 p.m. She indicated she was suppose to receive a new set of eye glasses. She had been waiting for 3 years and had never received them. She had not been seen by an eye doctor since admission. An interview was conducted with Social Services Director (SSD) on 3/4/26 at 2:49 p.m. She indicated Resident 50 had not been seen by an eye doctor since she had been admitted to the facility. She was unsure the reason why. A vision and hearing services policy was provided by the Nurse Consultant on 3/6/26 at 12:26 p.m. It indicated, Policy: It is the policy of this facility to ensure that residents are provided with vision and hearing services as needed. 410 IAC (Indiana Administrative Code) 16-3.1-39(a)(1)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on interview and record review, the facility failed to care plan behaviors and interventions for 1 of 1 resident reviewed for behavior management. (Resident 49) Findings include:The clinical record for Resident 49 was reviewed on 3/5/2026 at 4:00 PM. The medical diagnoses included, but were not limited to, anxiety, depression, and encephalopathy. An annual minimum data set assessment, dated 12/9/2025, indicated Resident 49 was cognitively intact, did not exhibit behaviors, hallucinations, delusions, or refusals of care. A care plan, dated 5/22/2024 and revised on 3/4/2026, indicated Resident 49 would refuse medications and weights. The interventions included, but were not limited to, providing space and educate Resident 49 on possible negative effects of refusing medications and weights. A care plan, dated 2/2/2026 and revised on 3/4/2026, indicated Resident 49 exhibited behaviors of becoming tearful. The interventions included, but were not limited to, provide psychosocial support and redirect as needed. A care plan, initiated 3/2/2026, indicated Resident 49 would become combative and aggressive when told she could not be in restricted areas. The interventions included, but were not limited to, to approach calmly, to maintain a safe distance, and ensure safety of the Resident 49. A care plan, dated 3/4/2026 and last revised on 3/4/2026, indicated Resident 49 had a history of becoming verbally or physically aggressive with staff if she could have what she wanted immediately. The interventions included, but were not limited, maintain safe distances, use calm reassurance, and use name and establish eye contact. A behavior note, dated 8/9/2025, indicated Resident 49 was arguing with a staff member about showering independently. An IDT (intradisciplinary team) progress note indicated on 8/12/2025 Resident 49 had a verbal episode of calling a staff member names and cursing. The progress note indicated the care plan was updated, and interventions included to educate Resident 49 about allowing staff to stand on the other side of the curtain when showering and the potential risk for not allowing care. The refusal care plan for Resident 49 did not list these interventions. A nursing progress note, dated 10/1/2025, indicated that Resident 49 became very verbally agitated and used extreme profanity. A nursing progress note, dated 10/30/2025, indicated Resident 49 was yelling at the nurses' station. During an interview with the Social Services Director, on 3/6/2026 at 12:36 p.m., she indicated Resident 49 had a history of behaviors including verbal aggression towards staff. Resident 49 would get fixated on things or people but Resident 49 had interventions which were helpful like preferred caregivers and diversional activities such as getting her nails done. SSD confirmed there were not on Resident 49's care plan nor were her verbally aggressive behaviors care planned prior to 3/4/2026. A policy, entitled Behaviors Management, was provided electronically by the Executive Director, on Friday, March 6, 2026, at 10:57 AM. The policy indicated, .Care plans should be initiated for any behavioral expression that is problematic or distressing to the resident, other resident or caregivers. Care plan interventions should include individualized and non-pharmacological interventions which address both proactive and responsive interventions. For behaviors which are new, worsening, or high risk, the nurse will record the staff should initiate an event in the charting system. New/Worsening Behaviors are defined as behaviors that are new for the resident, behaviors that are directed at another resident, Behaviors that are increasing in either frequency or severity, or behaviors that have potential for risk to others including sexual advances, intrusive wandering, exit seeking and chronic combativeness with care. If the behavioral expression is not new, worsening or high risk, the nurse will record the behavior in the progress notes for the IDT team to review the next day. If the behavior needed and IDT response then a behavior review would be complete, but if not, then the care plan would be reviewed and updated as needed. 410 IAC (Indiana Administrative Code) 16.3.1-37(1)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, interview, and record review, the facility failed to provide assistance with scheduling and tracking dental services for 2 of 2 reviewed for dental services. (Resident 7 and Resident 25).Findings include: 1 The clinical record for Resident 7 was reviewed on 3/3/26 at 9:27 a.m. The resident's diagnoses included, but were not limited to, diabetes and hypertension (high blood pressure). A Request for Information from the facility dental provider form, dated 10/3/24, indicated Resident 7 consented to receive dental services. A Concern/Grievance Form, dated 11/11/24, indicated Resident 7 wanted to be seen by dental services. The resident was added the list to be seen by dental services on 11/20/24. A progress note, dated 11/21/24, indicated the dental provider had contacted the facility about an outstanding bill with the provider. Resident 7 had paid a portion of the bill but still had an outstanding balance. The outstanding bill needed to be paid in full before the dental provider would provide services. A Quarterly Minimum Data Set (MDS) Assessment, completed 12/22/25, indicated the resident was cognitively intact. A care plan, last reviewed 1/2/26, indicated Resident 7 was edentulous (absence of natural teeth) and wore upper and lower dentures. She was at risk for impaired dental hygiene. The goal was for her to be free from mouth pain, red or bleeding gums, and oral lesions. The interventions included, but was not limited to, dental consult as indicated. During an interview on 3/03/26 at 9:27 a.m., Resident 7 indicated her dentures were loose since she had lost weight. She would like to see about getting a new set of dentures. She had not seen the dentist about the loose dentures. During an interview on 3/3/26 at 2:26 p.m., the Social Service Director (SSD) indicated Resident 7 owed the dental provider an outstanding bill. The dental provider refused to see her until the bill was paid in full. The outstanding bill was from 2024. Resident 7 had not seen the dentist since she was readmitted to the facility in October 2024. During an interview on 3/04/26 at 2:58 p.m., the Executive Director indicated Social Services was working with the provider to work out the outstanding bill. 2. The clinical record for Resident 25 was reviewed on 3/2/26 at 3:30 p.m. The diagnosis included, but was not limited to: end stage renal disease (kidneys are functioning less than 10%). A quarterly Minimum Data Set (MDS) Assessment, completed 12/30/25, indicated the resident was cognitively intact. A dental care visit note, dated 3/19/25, indicated Resident 25 had received x-rays to send for prior authorization for a new partial and new set of dentures. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 6/27/25, indicated Resident 25 had an emergency dental appointment at 8:00 a.m. A physician's order, dated 7/16/25, indicated Resident 25 had an emergency dental appointment that day (7/16/25). Resident 25's clinical record did not include documentation that indicated the reason for the dental appointment nor if the resident made the 6/27/25 or 7/16/25 dental appointments. An interview was conducted with Resident 25 on 3/2/26 at 3:34 p.m. She indicated the dentist was supposed to address her dentures. They do not fit correctly. The bite was off. She had not been seen by a dentist in a while. An interview was conducted with the Social Services Director (SSD) on 3/4/26 at 2:49 p.m. She indicated Resident 25 had in the past been seen by an outside dentist. She was not in the role of social services prior to November 2025, but SSD had found a dental consultation that was in March 2025. That visit stated the resident was in the process of receiving prior authorization for new dentures. In July 2025, she had a dental appointment but did not make that appointment. SSD was unsure why the resident had not made that dental appointment. There was no documentation of the status of the new dentures or follow up on if the resident was needing a dental visit after July's missed appointment. On 2/10/26, Resident 25 had consented to receive dental services by the facility's dentist. A dental services policy was provided by the Nurse Consultant on 3/6/26 at 12:26 p.m. It indicated, Policy: The facility obtains needed dental services, including routine and emergency dental services, assists in providing these services and makes prompt referrals for dental services as needed. A Social Services Director description of position report was provided by the Director of Nursing on 3/6/26 at 10:35 a.m. It indicated, Summary of position functions: The Social Services Director provides medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident; and shares a responsibility toward creating and sustaining an environment that humanizes and individualizes each resident's living area. Essential position functions:.Collaborates with other departments, physicians, consultants, community agencies, and institutions to improve quality of services and to resolve identified problems.Demonstrates teamwork and prompt and regular attendance to work to ensure that quality care and services are provided to the residents. 410 IAC (Indiana Administrative Code) 16.3.1-34(a)