

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/01/2016
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER ROSEGATE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN 46237
------------------------------------------------------	-------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00205863.</p> <p>Complaint IN00205863 - Substantiated. Federal/State deficiencies related to allegation are cited at F323.</p> <p>Survey dates: July 29 and August 1, 2016</p> <p>Facility Number: 011149 Provider Number: 155757 AIM number: 200829340</p> <p>Census bed type: SNF: 20 SNF/NF: 127 Total: 147</p> <p>Census payor type: Medicare: 26 Medicaid: 75 Other: 46 Total: 147</p> <p>Sample: 3</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	Rosegate Village respectfully requests desk review in lieu of an on-site revisit	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/01/2016
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER ROSEGATE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN 46237
------------------------------------------------------	-------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0323 SS=D Bldg. 00	<p>Q.R. completed by 14466 on August 03, 2016.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to prevent a resident from having eloped from the facility for 1 of 3 residents reviewed for supervision to prevent elopement. (Resident #A)</p> <p>Findings include:</p> <p>The clinical record for Resident #A was reviewed on 7/29/2016 at 9:30 a.m. The record indicated Resident #A was admitted on 7/22/16. Diagnosis included, but not limited to delirium and dementia. A Brief Interview for Mental Status dated 7/22/16, indicated a score of 3, severe cognitive impairment. Resident #A was assessed as dependent on staff for daily decision making.</p> <p>A Care Plan dated 7/22/2016, indicated</p>	F 0323	<p>F- 323 –Hazards/Supervision/Devi ses</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> Upon Resident A's return to facility, facility notified MD, family, ED, and DNS. A new elopement assessment, skin assessment, vital signs were obtained. Upon return resident's wanderguard was checked for placement and function. Family stayed with resident one on one until approximately 10:00pm. 	08/10/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/01/2016
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER ROSEGATE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN 46237
------------------------------------------------------	-------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Resident #A is a new admission to the facility. Goal: Resident needs will be met. Interventions included, but were not limited to Wanderguard (system to alert staff that a resident is too close to an open exit door) to ankle, check placement every shift, function every night.</p> <p>The Admission Assessment dated 7/22/16, indicate Resident #A was not at risk for elopement.</p> <p>On 7/29/2016 at 9:30 a.m., observed Resident #A to reside on a locked unit. Resident #A was pleasant and quiet. Observed Wanderguard on left ankle. No wandering observed.</p> <p>On 8/1/2016 at 10:45 a.m., observed Resident #A to reside on a locked unit. Resident #A was conversing with other residents. Observed Wanderguard on left ankle. No wandering observed.</p> <p>On 7/29/2016 at 9:15 a.m., During interview with Director of Nursing indicated, staff (Weekend Manager) working on 7/24/2016, was not familiar with Resident #A and "probably did not recognize Resident #A as a resident."</p> <p>On 7/29/2016 at 9:45 a.m., Director Of Nursing (DON) provided an Internal Resident Event Investigation dated</p>		<p>Once family left, the facility initiated 5 minute checks starting at 10:05. The following day, resident was day cared in secured unit on 7/24/2016 until bed became available on the 7/25/2016. On 7/24/2016 5 minute checks were discontinued by physician to 15 minute checks once resident was moved to secured unit.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All residents that trigger to be at risk per elopement assessment have the potential to be affected by this alleged deficient practice. All resident that triggered to be at risk of elopement per assessment were identified and facility performed audit to ensure placement and function of wanderguards if required per assessment. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/01/2016	
NAME OF PROVIDER OR SUPPLIER ROSEGATE VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN 46237			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	7/24/2016. Review of the event indicated "Incident/Event: at 5:40 p.m. Weekend Manager (staff #1), was attempting to locate resident to draw labs. Was unable to locate resident in room, looked through facility. Staff unable to find. Notified Executive Director (ED) at 5:45 p.m. Immediately initiated elopement policy and procedure. Daughter-in-law in facility at this time. She (daughter-in-law) received a call at 5:49 p.m. from residents son that she [Resident #A] was located and being brought back to facility. Witness Statement of Incident/Event: A woman [first name] noted resident north of Stop 11 on Emerson, outside of the facility. Noted armband that stated [local hospital], took resident to [name] hospital where son was notified and asked for her [Resident #A] to be returned to facility. Son notified wife who was at the facility at 5:49 p.m. Resident was returned. No area noted on skin assessment upon return. Vital signs obtained and within normal limits, no distress noted. Family stayed with resident until between 9:45 p.m. and 10:00 p.m. No injury noted. Intervention: Family one on one until 9:45 p.m. - 10:00 p.m. initiated checks every 15 minutes until resident moved to locked unit. Resident to be moved to locked unit on 7/25/16...."		<ul style="list-style-type: none"> · Facility placed a standing sign located at the door stating "Our Residents are very important to us. Please check with our nurse's station before assisting anyone outside," and sign on door was placed stating "Please keep our residents safe." · Facility contacted Integrated Electronic conducted an independent service check on 7/28/2016 to ensure all door locking systems, including the Wonder guard system, were functioning properly. Upon completion of service check, all door locking systems, including the wanderguard system, all systems were found to be working properly. · An all staff in-service on elopement risk supervision, procedure, and wanderguard placement and function was initiated on July 23, 2016. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/01/2016
NAME OF PROVIDER OR SUPPLIER ROSEGATE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN 46237		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>On 8/1/2016 at 11:06 a.m., during interview with the D.O.N., indicated sometimes the Wanderguard alarm goes off, because someone has pushed on the door for more than 15 seconds.</p> <p>On 8/1/2016 at 10:00 a.m., During interview with Weekend Manager (WM) indicated, when the Wanderguard alarm sounded on 7/24/16, she (WM) noticed the 300 hall exit door was flashing. She (WM) sent staff to other doors while she (WM) checked the 300 hall exit door. After noticing no activity at that door, she (WM) then went to the front door and checked outside. She (WM) observed approximately five residents outside on the porch "regulars." She (WM) then went back inside the building and shut off the Wanderguard alarm. Resident #A's daughter was coming in the door at the same time and did not notice Resident #A outside. "Sometimes it goes off when someone pushes on it for 15 seconds." (WM) then went to Resident #A's room to draw labs and noted she (Resident A) was not in her room. Elopement procedure was initiated at that time.</p> <p>On 8/1/2016 at 11:30 a.m.. During interview with the D.O.N. indicated, no one monitors the doors on non-business hours and on the weekends.</p>		<p>does not recur?</p> <ul style="list-style-type: none"> · To provide additional supervision, facility installed additional wonder guard system approximately 30 feet from existing wonder guard security system on 8/5/2016. This will alert and provide additional staff supervision prior to residents reaching second level of security that an elopement risk is approaching an exterior doors. If a resident is not immediately identified, facility will initiate elopement procedures, if unsupervised door staff will exit facility and search area, stop any person\ persons in the area and interview them, if no resident identified outside of facility a head count will be performed. · An all staff in-service on elopement risk supervision, procedure, and wonderguard placement and function was initiate on July 23, 2016. · DNS and/or designee will perform an elopement drills daily X 14 days, weekly X 4 weeks, monthly 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/01/2016
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER ROSEGATE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN 46237
------------------------------------------------------	-------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>On 8/1/2016 at 2:03 p.m., Observed sign next to door indicated, "our Residents are very important to us. Please check with our nurses station before assisting anyone outside." Sign on door indicated, "please keep our residents safe. Please sign in/out in our visitors book. Please be mindful of our residents when exiting our facility and make sure they do not exit with you unless you sign them out."</p> <p>On 8/1/2016 at 12:10 p.m., the D.O.N. provided an Elopement (Risk and Missing Resident) policy and procedure dated 10/2013, and indicated it was the one currently being used by the facility. A review of the policy indicated, "Policy: It is the policy of the facility that staff who have residents under their care are responsible for knowing the location of those residents, and in the case of a missing resident, ensuring appropriate action is taken...."</p> <p>This Federal tag relates to Complaint IN00205863.</p> <p>3.1-45(a)(2)</p>		<p>X 6 months, and quarterly thereafter for 2 quarters to check staff response time to wanderguard alarm.</p> <p>How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> A CQI "Elopement Supervision" audit tool will be utilized to monitor compliance with wanderguard placement, function, and elopement drill response time. Resident wonder guards will be observed weekly X 4 weeks, monthly X 6 months, and quarterly thereafter for at least 2 Quarters. Results of these evaluation processes will be presented to the CQI Committee monthly to review for compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action. If threshold of 95% is 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/01/2016
NAME OF PROVIDER OR SUPPLIER ROSEGATE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN 46237		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
			not achieved, an action plan will be developed to achieve desired threshold. Data will be submitted to the CQI committee for review and follow up. Compliance Date: 8/10/2016		