

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 09/11/2014
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NAME OF PROVIDER OR SUPPLIER ROSEGATE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN 46237
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F000000	<p>This visit was for the Investigation of Complaint IN00155595.</p> <p>Complaint IN00155595 - Substantiated. Federal/state deficiencies related to the allegations are cited at F-323.</p> <p>Survey dates: September 10 and 11, 2014</p> <p>Facility number: 011149 Provider number: 155757 AIM number: 200829340</p> <p>Survey team: Diana Zgonc, RN-TC</p> <p>Census bed type: SNF: 24 SNF/NF: 120 Total: 144</p> <p>Census payor type: Medicare: 31 Medicaid: 80 Other: 33 Total: 144</p> <p>Sample: 3</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC</p>	F000000	Rosegate Village is respectfully requesting a Face-To-Face IDR as facility disagrees with the scope and severity assigned to F323.	

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.

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F000323 SS=G	<p>16.2-3.1.</p> <p>Quality review completed on September 17, 2014; by Kimberly Perigo, RN.</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 record review and interview, the facility failed to ensure a resident had proper supervision to prevent a fall while using a bed pan which resulted in a fall and neck fracture for 1 of 3 residents reviewed for falls (Resident #B).</p> <p>Findings include:</p> <p>The closed clinical record for Resident #B was reviewed 9/10/14 at 10:20 a.m. Diagnoses for Resident #B included, but were not limited to, left side weakness, cerebrovascular accident (CVA-stroke), left leg venous thrombosis (DVT), ischemic heart disease and congestive heart failure.</p>	F000323	<p>F323 Free of accident hazards/Supervision/Devices It is the practice of this provider to ensure the resident's environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident B: no longer resides at this facility. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken · All residents have the potential to be affected by the alleged deficient</p>	10/08/2014

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	<p>A current Minimum Data Set (MDS) assessment dated 6/12/14, indicated the resident's cognitive status (BIMS-13) was intact (could make wants and needs known). The MDS also indicated the resident was at risk for falling.</p> <p>A care plan dated 6/5/14, indicated the resident was at risk for falls due to a history of falling and had a non-ambulatory status related to a recent CVA, DVT and pain. The care plan goal was the resident would be free from fall related injuries. Interventions in place to prevent a fall included wheelchair and bed alarms, non-skid footwear, therapy to screen and treat as needed, and call light within reach.</p> <p>An Occupational Therapy Plan of Care dated 6/6/14, indicated Resident #B was evaluated and was unable to maintain balance without moderate/maximum support.</p> <p>An "Event Report" dated 7/9/14, indicated the resident was found (unwitnessed) on the floor in his room. Resident #B reported to the nurse he could not find the remote (call light attached to the remote) so he placed himself on the floor. Prior documentation in the Nurses notes indicated Resident #B was having</p>		<p>practice. · Nursing Staff have been educated on the fall management program and bedpan supervision by Director of Nursing/designee by October 8, 2014. · DNS/designee reviewed all resident fall/toileting care plans of residents that have a history of falls and utilize bedpans to ensure care plan addresses the necessary supervision while utilizing bedpan and as allowed by the resident. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur · Nursing Staff have been educated on the fall management program and providing bedpan supervision per plan of care by Director of Nursing/designee by October 8, 2014. · Nursing Staff will remain with any resident that has a history of falls and utilizes a bedpan unless not allowed by the resident. If the resident asks for privacy the nursing staff member will place the bed in the lowest locked position, place a floor mat next to the bed, place call light within reach and stand behind the resident's privacy curtain. If the resident asks the nursing staff to leave the room entirely the staff member will leave the room and remain outside resident's door until the resident has indicated they are finished; resident care plan will be updated accordingly regarding bedpan supervision. ·</p>	

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	<p>difficulty identifying and using the call light. A low profile mat was added to the left side of the bed and bright tape was placed on the call light to identify it.</p> <p>An "Event Report" dated 7/11/14 at 11:55 a.m., indicated the resident was found on floor in his room. Prior to the fall the resident had been in bed on the bed pan. Resident #B reported to the nurse he was reaching for the remote and fell out of bed. The "Event Report" indicated the remote and call light were clipped to the resident. X-ray report of the neck was negative for injury.</p> <p>A CT Scan (cat scan) was ordered on 7/14/14, for continued complaints of neck pain. On 7/15/14, the family requested the CT Scan to be canceled and the resident sent to the ER.</p> <p>A hospital ER note dated 7/15/14, indicated the resident had a CT Scan of the cervical spine and the report revealed a C2 (cervical vertebrae #2) fracture.</p> <p>During an interview with CNA #1 on 9/11/14 at 9:35 a.m., she indicated she was taking care of the resident when he fell. She sat the resident up in bed, provided the resident with the bedpan, and then left the room at his request. She further indicated the resident always</p>		<p>Staff to make daily rounds on every shift on residents that utilize bedpans and have a history of falls to verify that resident's plan of care related to bedpan supervision is being followed utilizing safety rounds audit tool. · All residents with a history of falls will be reviewed quarterly and significant change to ensure appropriate/interventions are in place by the IDT team and care plan will be updated accordingly regarding bedpan supervision.</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"> · The bedpan supervision CQI tool will be utilized weekly x 4, monthly x 6, quarterly thereafter. · The CQI committee will review the data. If a 95% threshold is not achieved, an action plan will be developed. Compliance date: October 8, 2014. 	

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	<p>requested her to leave the room when he was using the bedpan. In a few minutes he started yelling that he had fallen. She found him on the mat on the floor on his left side (CVA affected side).</p> <p>During an interview with Occupational Therapist #2 on 9/11/14 at 12:00 p.m., she indicated the resident was not appropriate for a bedside commode or toileting in the bathroom due to poor trunk control. A bedpan would be appropriate for him.</p> <p>A current facility policy dated 7/01, revised 9/2013 and titled, "Fall Management Program" and provided by the Administrator on 9/11/14 at 12:50 p.m., indicated: "Policy: It is the policy of (name of facility) to ensure residents residing within the facility will maintain maximum functioning through the establishment of physical ... guidelines to prevent injury related to falls."</p> <p>This Federal tag relates to the Complaint IN00155595.</p> <p>3.1-45(a)(2)</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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