

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 11/08/2013
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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 Complaints IN00134913 and IN00135155.</p> <p>Complaint IN00134913 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00135155 - Substantiated. Federal/state deficiencies related to the allegations are cited at F465.</p> <p>Survey dates: November 7 & 8, 2013</p> <p>Facility number: 011149 Provider number: 155757 AIM number: 200829340</p> <p>Survey team: Susan Worsham, RN-TC</p> <p>Census bed type: SNF: 39 SNF/NF: 107 Total: 146</p> <p>Census payor type: Medicare: 26 Medicaid: 79 Other: 41 Total: 146</p>	F000000	Rosegate Village is respectfully requesting paper compliance review. If you have any question please don't hesitate to call Ryan Levensgood, Executive Director, at the facility phone number of (317)889-9300.	

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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	<p>Sample: 06</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on November 18, 2013; by Kimberly Perigo, RN.</p>				

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F000465 SS=D	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure Resident# A had a clean environment in that Resident #A's mattress had an odor of urine. This affected 1 out of 6 residents reviewed for sanitary and comfortable environment.</p> <p>Findings include:</p> <p>During a confidential interview on 11/7/13 at 2:13 p.m., [gender] indicated [gender] had visited Resident #A on November 2, 2013, noting that [gender] bed had a slight odor of urine coming from it. Visitor indicated they had advised staff.</p> <p>On 11/7/13 at 2:55 p.m., observation of Resident# A's bed indicated a smell of urine coming from the mattress. DON was requested to check Resident #A's mattress at that time, and indicated she agreed there was a smell of urine coming from the mattress and Resident #A's mattress would be removed immediately, deep-cleaned, and another mattress placed on Resident #A's bed.</p>	F000465	F465What plan of correction (POC) will be accomplished for those residents found to have been affected by the deficient practice.1.)The Director of Nursing (DON) checked resident A's mattress as soon as she was made aware of the odor concern, the mattress was removed immediately, deep-cleaned, and another mattress was placed on resident A's bed. Resident A's mattress will be deep cleaned weekly and as needed by housekeeping. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.2.)All residents in the facility have the potential to be affected. Each room was inspected for odor by the resident's assigned customer care representative and any corrective action that was needed was immediately addressed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.3) Facility Interdisciplinary Team (IDT) will review the Housekeeping Policy and Procedures cleaning guidelines and educating the IDT	12/08/2013			

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	<p>Observation on 11/8/13, at 10:00 a.m., indicated there was a new mattress on the bed and no odor of urine was noted.</p> <p>This Federal tag relates to Complaint IN00135155.</p> <p>3.1-19(f)</p>		<p>Team on the additional check off for odor free rooms on the Care Rep Daily Visits: Observation and Resident Feedback Form. An in-service with post test for nursing staff and housekeeping staff will be completed on or before December 8th, 2013 by the Clinical Education Coordinator or qualified designee on the proper procedure and schedule of cleaning resident mattresses. Each department head is responsible for completing daily room rounds which include inspecting the environment and checking for any odors. They will complete a CARE Rep Daily Visits: Observation and Resident Feedback Form for five days a week and the weekend manager on duty will complete the same audit tool for twenty five randomly selected resident rooms. Additionally, housekeeping will continue to follow their deep cleaning schedule and complete daily room rounds and address any environmental concerns noted and will report to the housekeeping supervisor qualified designee if any environmental factors cannot be resolved in a timely manner.</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; and by what date the systemic changes will be completed.4)The Executive Director/Qualified</p>		

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			Designee is responsible for the completion of the Laundry Housekeeping Cleaning Schedule CQI audit tool and the Customer Care Tracking Audit Tool for 95% compliance for environmental audits (if threshold is not achieved an action plan will be developed) for four weeks, then quarterly thereafter for two cycles for at least six months with results reported to the CQI committee over seen by the Executive Director if threshold is not achieved action plan will be developed to ensure compliance.	