STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155757	A. BUILDING -- B. WING	12/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/02/24 Facility Number: 011149 Provider Number: 155757 AIM Number: 200829340 At this Emergency Preparedness survey, Rosegate Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 150 certified beds. At the time of the survey, the census was 134. Quality Review completed on 12/09/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/02/24 Facility Number: 011149 Provider Number: 155757 AIM Number: 200829340 At this Life Safety Code survey, Rosegate Village was found not in compliance with Requirements	K 0000	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspection Report. Rosegate respectfully requests consideration for a desk	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tara McGlothlin	Executive Director	12/20/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155757	A. BUILDING 01 B. WING	12/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 150 and a census of 134. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 12/09/24		review of this plan of correction in lieu of post survey revisit.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 1 of over 20 hazardous areas such as trash collection rooms (exceeding 64 gallons) was separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 20 residents, staff and visitors in the main Dining Room. Findings include: Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 1:00 p.m. to 3:25	K 0321	**K321 Hazardous areas-enclosures** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Maintenance Director adjusted the door closer to assure proper closing. **How will you identify other residents having the potential to be affected by the same**	12/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155757	A. BUILDING 01 B. WING	12/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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.m. on 12/02/24, the entry door to the kitchen from the main dining room was equipped with latching hardware and a self-closing device but the door failed to self-close and latch into the door frame when tested to close multiple times. The kitchen door would only fully self-close and latch into the door frame when the range hood kitchen exhaust was turned off. The kitchen contained over three 32 gallon capacity trash receptacles. Based on interview at the time of the observations, the Maintenance Director agreed the kitchen door would not fully self-close and latch into the door frame when tested to close with the kitchen exhaust fan on and agreed the aforementioned hazardous area was not separated from other spaces by smoke resistant partitions and doors. These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		**deficient practice and what corrective action will be taken?** All residents of the facility have the potential to be affected by the alleged deficient practice. All other hazardous areas were checked by Maintenance Director to ensure trash collection rooms was separated from other spaces by smoke resistant partitions and door. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Door will be monitored via QA tool/ rounds and observation for continued function. **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?** ·Life Safety QA tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
K 0324 SS=E	NFPA 101 Cooking Facilities			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155757	A. BUILDING 01 B. WING	12/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
Bldg. 01	Based on observation and interview, the facility failed to ensure 1 of 1 griddles used for frying in the 100 Hall Dining Room was provided with an exhaust system that complies with NFPA 96. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 4.1.1 states cooking equipment used in processes producing smoke or grease laden vapors shall be equipped with an exhaust system that complies with all the equipment and performance standards of this standard. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the 100 Hall Dining Room. Findings include: Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 1:00 p.m. to 3:25 p.m. on 12/02/24, a griddle used for frying was plugged in to a wall mounted outlet box and placed on the countertop underneath the wall mounted cabinets near the sink in the 100 Hall Dining Room. The griddle had a grease film on it with bread crumbs stuck to the griddle. The griddle and the 100 Hall Dining Room were not equipped with an exhaust system suitable for the production of grease laden vapors by cooking. Based on interview at the time of the observations, the Maintenance Supervisor agreed the griddle had been in use and was not located underneath an exhaust system suitable for the production of grease laden vapors. These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference.	K 0324	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Griddle was removed from 100 hall dining room. **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 of the facility have the potential to be affected by the alleged deficient practice. All other dining rooms were checked by Maintenance director to ensure cooking equipment is not used without the appropriate exhaust system **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Griddle was removed. Eggs will be prepared in the kitchen vs steam table and kitchenette area on the hall. Will monitor that griddle is not in 100 hall dining room via QA tool/ rounds and observation for continued compliance. Staff educated by ED/Designee to ensure griddle is not used in facility without	12/03/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155757	A. BUILDING 01 B. WING	12/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	3.1-19(b)		appropriate exhaust system. **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?** ·Life Safety QA tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of over 50 corridor doors to resident sleeping rooms had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of resident sleeping Room 404. Findings include: Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 1:00 p.m. to 3:25 p.m. on 12/02/24, the corridor door to resident sleeping Room 404 was propped in the fully open position with a trash can placed on the floor up	K 0363	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Hinges replaced on the door to room 404. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? • Residents in room 404 have the potential to be affected by the alleged deficient practice. All other resident room	12/16/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155757	A. BUILDING 01 B. WING	12/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	against the door. In addition, a one inch gap was noted in between the face of the door and the door stop just above the floor when the corridor door to Room 404 was in the fully closed and latched position. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned corridor door had an impediment to latching into the door frame and would not resist the passage of smoke. These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		doors were checked to ensure proper closure What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • Corridor doors are reviewed via QA tool/ rounds and observation for continued function. 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? • Life Safety QA tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director • If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
K 0761 SS=E Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors 1. Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved	K 0761	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Inspections completed on 200, 400 and 500 furnace rooms.	01/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155757	A. BUILDING 01 B. WING	12/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, Section 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position.		Inspections documented in TELS. Overhead garage doors contacted. Will install a replacement firefly on kitchen shutter. Replacement has been ordered. Awaiting parts delivery and installation. **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 of the facility have the potential to be affected by the alleged deficient practice. All fire door assemblies were inspected to ensure each was completed annually by the maintenance director. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Inspections for furnace room doors was added to TELS for routine inspection. Firefly replacement to the kitchen shutter. **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?** ·Life Safety QA tool will be utilized weekly x 4 weeks,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155757	A. BUILDING 01 B. WING	12/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Fire/Smoke Door Inspection" documentation dated 04/29/24 with the Maintenance Director and the Field Maintenance Supervisor during record review from 9:05 a.m. to 12:30 p.m. on 12/02/24, annual inspection documentation of fire door assemblies in the facility within the most recent twelve month period did not include all fire doors in the facility. The annual inspection documentation dated 04/29/24 did not include fire door locations at natural gas fired furnace room locations in the 200 Hall, 400 Hall and 500 Hall. Based on interview at the time of record review, the Maintenance Director provided annual fire door inspection documentation dated 04/28/23 for the aforementioned three fire door locations but agreed fire door inspection documentation for these three fire door locations in the most recent twelve month period was not available for review. Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 1:00 p.m. to 3:25 p.m. on 12/02/24, the corridor door to the 200 Hall Mechanical Room, the 400 Hall Mechanical Room		monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155757	A. BUILDING 01 B. WING	12/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	and the 500 Hall Mechanical Room were each a fire-rated door with a minimum 1-hour fire resistance rating label affixed to the hinge side of the door. Each Mechanical Room was located near the center nurse's station and each Mechanical Room contained one natural gas fired furnace. Based on interview at the time of the observations, the Maintenance Director and the Field Maintenance Supervisor agreed it could not be ensured all fire door locations in the facility were included in the most recent annual fire door inspection documentation. These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the proper operation of 1 rolling steel fire door was maintained in accordance with NFPA 80. LSC 4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 2010 Edition, the Standard for Fire Doors and Other Opening Protectives, Section 11.4.1.1 requires an automatic-closing device shall be installed on every rolling steel door. Section 11.4.1.2 states rolling steel doors shall close automatically upon activation or release of a fusible link or detector. Section 11.4.2.2.1 states that after the automatic closing is activated, the door shall remain in the closed position until the automatic-closing device			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155757	A. BUILDING 01 B. WING	12/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	has been reset. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. This deficient practice could affect over 20 residents, staff and visitors in the main Dining Room. Findings include: Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 1:00 p.m. to 3:25 p.m. on 12/02/24, the metal rolling fire door between the kitchen and main Dining Room was equipped with a fusible link for self-closing or automatic closing but annual inspection and testing documentation to ensure the rolling steel door would close automatically upon activation or release of a fusible link or detector was not available for review. Based on interview at the time of record review, the Maintenance Director agreed that annual inspection and testing documentation for the rolling steel door was not available for review. These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155757	A. BUILDING 01 B. WING	12/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
K 0914 SS=D Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Based on record review, observation and interview; the facility failed to ensure 1 of over 6 nonhospital-grade electrical receptacles in resident sleeping Room 103 were maintained in accordance with NFPA 99, Health Care Facilities Code. NFPA 99, 2012 Edition, Section 6.3.3.2.4 states the retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 oz.). NFPA 70, The National Electrical Code, 2011 Edition, at Article 517.18(B) states each patient bed location shall be provided with a minimum of four receptacles. They shall be permitted to be of the single, duplex, or quadruplex type, or any combination of the three. All receptacles, whether four or more, shall be listed "hospital grade" and so identified. It is not intended that there be a total, immediate replacement of existing non-hospital grade receptacles. It is intended, however, that non-hospital grade receptacles be replaced with hospital grade receptacles upon modification of use, renovation, or as existing receptacles need replacement. This deficient practice could affect 2 residents and staff in resident sleeping Room 103. Findings include: Based on review of "Receptacle Testing" documentation dated 06/24/24 with the Maintenance Director and the Field Maintenance Supervisor during record review from 9:05 a.m. to 12:30 p.m. on 12/02/24, no deficiencies were noted for annual electrical receptacle testing in resident sleeping Room 103. Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the	K 0914	How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? • Residents in room103 have the potential to be affected by the alleged deficient practice. All receptacles in residents rooms were checked by the maintenance director to ensure proper retention force. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • Receptacles will be reviewed during maintenance rounds. 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? • Life Safety QA tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director • If a threshold of 95% is not achieved, an action plan will be developed to ensure	12/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155757	A. BUILDING 01 B. WING	12/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	facility from 1:00 p.m. to 3:25 p.m. on 12/02/24, the top nonhospital-grade electrical receptacle in the wall mounted outlet box for two electrical receptacles located next to the wall mounted quad outlet box for the resident bed nearest the corridor door in resident sleeping Room 103 was found to have no retention force when tested with the facility's retention force testing device. The receptacle was first tested with an Ideal Industries GFCI testing device which found no resistance to removing the testing device after insertion for testing electrical wiring issues such as an open ground or hot neutral. The Maintenance Director then inserted the facility's retention testing device which registered zero retention force. Based on interview at the time of the observations, the Maintenance Director indicated there must have been a change to the receptacle after 06/24/24 testing and agreed the aforementioned electrical receptacle now fails retention force testing. These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		compliance	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables	K 0920	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Maintenance Director immediately corrected the concern during survey. Staff and resident education provided. Label added to power strip.	12/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155757	A. BUILDING 01 B. WING	12/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect 2 residents, staff and visitors in resident sleeping Room 406. Findings include: Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 1:00 p.m. to 3:25 p.m. on 12/02/24, a cell phone charging cable and an oxygen concentrator were plugged into a power strip placed on the floor within one foot of the resident bed nearest the window in resident sleeping Room 406. The UL listing of the power strip was 1363A. Based on interview at the time of the observations, the Maintenance Director agreed a power strip was being used in the patient care vicinity for PCREE and non-PCREE and was also being used as a substitute for fixed wiring in the aforementioned resident sleeping room.		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 of the facility have the potential to be affected by the alleged deficient practice. Maintenance director checked all power strips to ensure appropriate usage. Staff educated on the proper use of power strips. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Label added to power strip. Maintenance Director or designee will review that power strips do not have medical equipment plugged in along with non medical items via QA tool/ rounds and observation for continued compliance. 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? • Life Safety QA tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155757	A. BUILDING 01 B. WING	12/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		Executive Director • If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	