STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CI AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155757			X2) MULTIPLE CONSTRUCTION (X3) DATE SUR A. BUILDING COMPLETE B. WING 12/02/202			ETED	
NAME OF P	PROVIDER OR SUPPLIEF	<b>t</b>			ADDRESS, CITY, STATE, ZIP COD OSEGATE DR		
ROSEGA	ATE VILLAGE				IAPOLIS, IN 46237		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
E 0000	REGULATORT OF	CESC IDENTIFY TING INFORMATION		TAG			DATE
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 00	000			
K 0000		•					
Bldg. 01	A Life Safety Code	Recertification and State	KO	000	This plan of correction constitu	utes	
	Licensure Survey w Department of Head 483.90(a). Survey Date: 12/02 Facility Number: 0 Provider Number: AIM Number: 200 At this Life Safety	vas conducted by the Indiana Ith in accordance with 42 CFR 2/24 111149 155757	K 0	<b>900</b>	This plan of correction constituthis facility's written allegation compliance for the deficiencie cited. The submission of this pof correction is not an admission or agreement with the deficier or conclusions contained in the Indiana Department of Health inspection  Report. Rosegate respectfully requests consideration for a difference of the submission	of s blan of ncies	

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

(X6) DATE

TITLE

Tara McGlothlin Executive Director 12/20/2024

Any defiency statement 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 disclodays 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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		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 12/02/2024	
	ROVIDER OR SUPPLIER		7510 R	ADDRESS, CITY, STATE, ZIP COD ROSEGATE DR NAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Subpart 483.90(a), I 2012 edition of the Association (NFPA Chapter 19, Existing 410 IAC 16.2.	Medicare/Medicaid, 42 CFR Life Safety from Fire and the National Fire Protection ) 101, Life Safety Code (LSC), g Health Care Occupancies and ity was determined to be of		review of this plan of correction in lieu of post survey revisit.	
	The facility has a find etection in the corridor. The fahard wired to the firm	ruction and fully sprinklered. re alarm system with smoke ridors and in all areas open to acility has smoke detectors re alarm system in all resident e facility has a capacity of 150			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas				
	failed to ensure 1 of as trash collection re	on and interview, the facility Fover 20 hazardous areas such coms (exceeding 64 gallons) other spaces by smoke	K 0321	K321 Hazardous areas- enclosures	12/20/2024
	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.			What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?  Maintenance Director adjusted	n
	Director and the Fie	ons with the Maintenance eld Maintenance Supervisor facility from 1:00 p.m. to 3:25		door closer to assure proper closing.  How will you identify other residents having the potentiato be affected by the same	al

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STATEME	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILI	DING	01	COMPLETED		
		155757	B. WING	·		12/02/	2024	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF	PROVIDER OR SUPPLIE	3			OSEGATE DR			
ROSEG	ATE VILLAGE				APOLIS, IN 46237			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PR	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	1	ΓAG	DEFICIENCY)	-	DATE	
	1 *	he entry door to the kitchen			deficient practice and what			
		ng room was equipped with			corrective action will be take	n?		
	_	and a self-closing device but			All residents of the facility			
		elf-close and latch into the			have the potential to be affect			
		ested to close multiple times.			by the alleged deficient praction			
		ould only fully self-close and			All other hazardous areas wer			
		frame when the range hood			checked by Maintenance Dire			
	kitchen exhaust was turned off. The kitchen contained over three 32 gallon capacity trash				to ensure trash collection roon			
					was separated from other spa			
	receptacles. Based on interview at the time of the				by smoke resistant partitions a	and		
	observations, the Maintenance Director agreed				door.			
	the kitchen door wo			What measures will be put in	ito			
	latch into the door frame when tested to close				place or what systemic			
		haust fan on and agreed the			changes you will make to			
		zardous area was not separated			ensure that the deficient			
		by smoke resistant partitions			practice does not recur?			
	and doors.				Door will be monitored via			
	Tri (* 1'				tool/ rounds and observation f	or		
		e reviewed with the Executive			continued function.			
	1	enance Director and the Field			11 41			
	conference.	visor during the exit			How the corrective action(s)			
	conference.				will be monitored to ensure t	ne		
	2.1.10/b)				deficient practice will not			
	3.1-19(b)				recur, i.e., what quality			
					assurance program will be p into place?	ut		
					-			
					·Life Safety QA tool will be utilized weekly x 4 weeks,			
					monthly x 6 months, and quar	torly		
					thereafter for one year with res	-		
					reported to the Quality Assura			
					and Performance Improvemen			
					Committee overseen by the			
					Executive Director			
					If a threshold of 95% is not			
					achieved, an action plan will b	e		
					developed to ensure complian			
K 0324	NFPA 101							
SS=E	Cooking Facilities	;						

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 12/02/2024 155757 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7510 ROSEGATE DR ROSEGATE VILLAGE INDIANAPOLIS, IN 46237 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Bldg. 01 Based on observation and interview, the facility K 0324 12/03/2024 failed to ensure 1 of 1 griddles used for frying in What corrective action(s) will the 100 Hall Dining Room was provided with an be accomplished for those exhaust system that complies with NFPA 96. residents found to have been NFPA 96, 2011 Edition, Standard for Ventilation affected by the deficient Control and Fire Protection of Commercial practice? Cooking Operations, Section 4.1.1 states cooking Griddle was removed from equipment used in processes producing smoke or 100 hall dining room. grease laden vapors shall be equipped with an exhaust system that complies with all the How will you identify other equipment and performance standards of this residents having the potential standard. This deficient practice could affect over to be affected by the same 20 residents, staff and visitors in the vicinity of deficient practice and what the 100 Hall Dining Room. corrective action will be taken? All residents of the facility Findings include: have the potential to be affected by the alleged deficient practice. Based on observations with the Maintenance All other dining rooms were Director and the Field Maintenance Supervisor checked by Maintenance director during a tour of the facility from 1:00 p.m. to 3:25 to ensure cooking equipment is p.m. on 12/02/24, a griddle used for frying was not used without the appropriate plugged in to a wall mounted outlet box and exhaust system placed on the countertop underneath the wall mounted cabinets near the sink in the 100 Hall What measures will be put into Dining Room. The griddle had a grease film on it place or what systemic with bread crumbs stuck to the griddle. The changes you will make to griddle and the 100 Hall Dining Room were not ensure that the deficient equipped with an exhaust system suitable for the practice does not recur? production of grease laden vapors by cooking. Griddle was removed. Eggs Based on interview at the time of the will be prepared in the kitchen vs observations, the Maintenance Supervisor agreed steam table and kitchenette area the griddle had been in use and was not located on the hall. underneath an exhaust system suitable for the Will monitor that griddle is not in 100 hall dining room via QA production of grease laden vapors.

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conference.

These findings were reviewed with the Executive

Director, the Maintenance Director and the Field

Maintenance Supervisor during the exit

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tool/ rounds and observation for

ED/Designee to ensure griddle is

continued compliance.

Staff educated by

not used in facility without

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155757	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 12/02/2024
	PROVIDER OR SUPPLIER		7510 F	ADDRESS, CITY, STATE, ZIP COD ROSEGATE DR NAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0363 SS=E	3.1-19(b)  NFPA 101 Corridor - Doors			appropriate exhaust system.  How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place?  Life Safety QA tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarthereafter for one year with rereported to the Quality Assurand Performance Improveme Committee overseen by the Executive Director  If a threshold of 95% is not achieved, an action plan will be developed to ensure complian	the  out  terly sults ance nt
Bldg. 01	failed to ensure 1 of resident sleeping ro closing and latching would resist the past practice could affect visitors in the vicinit 404.  Findings include:  Based on observation Director and the Fiedduring a tour of the p.m. on 12/02/24, the sleeping Room 404	on and interview, the facility Fover 50 corridor doors to oms had no impediment to g into the door frame and sage of smoke. This deficient t over 20 residents, staff and try of resident sleeping Room ons with the Maintenance and Maintenance Supervisor facility from 1:00 p.m. to 3:25 the corridor door to resident was propped in the fully open in can placed on the floor up	K 0363	What corrective action(s) will accomplished for those reside found to have been affected be deficient practice?  Hinges replaced on the door to room 404.  How will you identify other residents having the potential be affected by the same deficient practice and what corrective a will be taken?  Residents in room 404 have the potential to be affected by the alleged deficient practice.	ents by the  to ient action  4 ded ce.

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155757	B. W	ING		12/02/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			OSEGATE DR		
ROSEGA	TE VILLAGE			INDIANAPOLIS, IN 46237			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	RRECTION (X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	addition, a one inch gap was			doors were checked to ensure	<del>;</del>	
		the face of the door and the the floor when the corridor			proper closure		
		was in the fully closed and			What magazines will be put into	•	
		ased on interview at the time			What measures will be put into		
	-				place or what systemic change		
	of the observations, the Maintenance Director agreed the aforementioned corridor door had an				you will make to ensure that the		
	-	ning into the door frame and			deficient practice does not rec  Corridor doors are		
	would not resist the	_			reviewed via QA tool/ rounds		
	would not resist the	passage of smoke.			observation for continued fund		
	These findings wer	a raviawad with the Evacutive			observation for continued fund	Juon.	
	These findings were reviewed with the Executive Director, the Maintenance Director and the Field						
	· ·	visor during the exit			How the corrective action(s) w	ill bo	
	conference.	visor during the exit			monitored to ensure the defici		
	conference.				practice will not recur, i.e., who		
	3.1-19(b)				quality assurance program wil		
	3.1 17(0)				put into place?	i bc	
					Life Safety QA tool wil	l he	
					utilized weekly x 4 weeks,	I DC	
					monthly x 6 months, and quar	terly	
					thereafter for one year with re	-	
					reported to the Quality Assura		
					and Performance Improvemen		
					Committee overseen by the		
					Executive Director		
					If a threshold of 95% is	9	
					not achieved, an action plan w		
					be developed to ensure	,	
					compliance		
K 0761	NFPA 101						
SS=E Bldg. 01	Maintenance, Insp	pection & Testing - Doors					
_	1. Based on record	review, observation and	$K_0$	761	What corrective action(s) wil	ıl	01/10/2025
		ty failed to ensure annual			be accomplished for those		
		ng of all fire door assemblies			residents found to have been	n	
		accordance of LSC 19.1.1.4.1.1.			affected by the deficient		
	-	enings in dividing fire barriers			practice?		
		4.1 shall be permitted only in			Inspections completed on	1	
		be protected by approved			200, 400 and 500 furnace root		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155757		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 12/02/2024	
	PROVIDER OR SUPPLIER	R	7510 R	ADDRESS, CITY, STATE, ZIP COD OSEGATE DR IAPOLIS, IN 46237	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	8.3.) LSC 8.3.3.1 C protection rating by protected by approvassemblies and fire accompanying hard closing devices, and accordance with the Standard for Fire D Protectives, except Code. NFPA 80 5.2 shall be inspected a annually, and a wrishall be signed and AHJ. NFPA 80, 5.5 fire door and windoperformed by indiv	pre assemblies. (See also Section penings required to have a fire a Table 8.3.4.2 shall be area (listed, labeled fire door window assemblies and their aware, including all frames, chorage, and sills in a requirements of NFPA 80, coors and Other Opening as otherwise specified in this at the states fire door assemblies and tested not less than atten record of the inspection kept for inspection by the 2.3.1 states functional testing of the system of		Inspections documented in TE Overhead garage doors contacted. Will install a replacement firefly on kitchen shutter. Replacement has bee ordered. Awaiting parts deliver and installation.  How will you identify other residents having the potentia to be affected by the same deficient practice and what corrective action will be take All residents of the facility have the potential to be affecte by the alleged deficient practic All fire door assemblies we inspected to ensure each was	en y il n? ed e.
	80, 5.2.4.1 states fit visually inspected f	ng subject to testing. NFPA re door assemblies shall be from both sides to assess the		completed annually by the maintenance director.	
	following items sha (1) No open holes of either the door or fi (2) Glazing, vision are intact and secur equipped. (3) The door, frame noncombustible thr	5.2.4.2 states as a minimum, the all be verified: or breaks exist in surfaces of		What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?  Inspections for furnace roo doors was added to TELS for routine inspection.  Firefly replacement to the kitchen shutter.	
	damage. (4) No parts are mis (5) Door clearances listed in 4.8.4 and 6 (6) The self-closing	ssing or broken.		will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be puinto place?  Life Safety QA tool will be	

from the full open position.

utilized weekly x 4 weeks,

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED	
		155757	B. W	ING		12/02/		
				_	_		-	
NAME OF I	PROVIDER OR SUPPLIEF	₹			ET ADDRESS, CITY, STATE, ZIP COD			
50050	TE \ #   1 A O E				OSEGATE DR			
ROSEGA	ATE VILLAGE			INDIAN	APOLIS, IN 46237			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	rc	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	· C	DATE	
	(7) If a coordinator	is installed, the inactive leaf			monthly x 6 months, and quart	erly		
	closes before the ac	etive leaf.			thereafter for one year with res	sults		
	(8) Latching hardware operates and secures the				reported to the Quality Assura	nce		
	door when it is in the closed position.				and Performance Improvemer	ıt		
	(9) Auxiliary hardw	vare items that interfere or			Committee overseen by the			
	prohibit operation a	are not installed on the door or			Executive Director			
	frame.				·If a threshold of 95% is not			
	(10) No field modifications to the door assembly				achieved, an action plan will b	е		
	_	ed that void the label.			developed to ensure complian	ce		
		edge seals, where required, are						
		their presence and integrity.						
	This deficient practice could affect all residents,							
	staff and visitors.							
	Findings include:							
	Rosed on review of	"Fire/Smoke Door Inspection"						
		ed 04/29/24 with the						
		tor and the Field Maintenance						
		record review from 9:05 a.m. to						
		2/24, annual inspection						
	_	ire door assemblies in the						
		nost recent twelve month						
		ide all fire doors in the facility.						
	*	on documentation dated						
	_	clude fire door locations at						
		rnace room locations in the 200						
		500 Hall. Based on interview at						
		eview, the Maintenance						
	Director provided a	nnual fire door inspection						
	documentation date	ed 04/28/23 for the						
	aforementioned thr	ee fire door locations but						
	agreed fire door ins	pection documentation for						
	these three fire doo	r locations in the most recent						
	twelve month perio	d was not available for review.						
	_	ons with the Maintenance						
	Director and the Fig	eld Maintenance Supervisor						
	during a tour of the	facility from 1:00 p.m. to 3:25						
		he corridor door to the 200 Hall						
	Mechanical Room,	the 400 Hall Mechanical Room						

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

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155757	(X2) MUI A. BUI B. WIN	LDING	nstruction 01	(X3) DATE : COMPL 12/02/	ETED
	PROVIDER OR SUPPLIEI	₹		7510 RC	DDRESS, CITY, STATE, ZIP COD DSEGATE DR APOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	and the 500 Hall M fire-rated door with resistance rating lal the door. Each Me near the center nurs Mechanical Room furnace. Based on observations, the M Field Maintenance be ensured all fire of were included in the inspection document. These findings were Director, the Maintenance Superconference.  3.1-19(b)  2. Based on observer failed to ensure the steel fire door was NFPA 80. LSC 4.3 equipment, system, of protection, or an compliance with the device, equipment, arrangement, level shall thereafter be recempts such main Edition, the Standar Opening Protective automatic-closing of every rolling steel doors a activation or releas Section 11.4.2.2.1 sclosing is activated	dechanical Room were each a a minimum 1-hour fire only affixed to the hinge side of chanical Room was located se's station and each contained one natural gas fired interview at the time of the diaintenance Director and the Supervisor agreed it could not cloor locations in the facility e most recent annual fire door notation.  The reviewed with the Executive enance Director and the Field enance					

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

PRINTED: 12/31/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES  N OF CORRECTION	IDENTIFICATION NUMBER  155757	l í	JILDING	01	COMPL 12/02/	ETED
	PROVIDER OR SUPPLIEF	2		7510 RG	DDRESS, CITY, STATE, ZIP COD DSEGATE DR APOLIS, IN 46237		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	has been reset. NFI assemblies shall be than annually, and a inspection shall be by the AHJ. NFPA testing of fire door be performed by incunderstanding of the type of door bei 80, 5.2.4.1 states fin visually inspected for overall condition of practice could affect visitors in the main.  Findings include:  Based on observation Director and the Finduring a tour of the p.m. on 12/02/24, the between the kitcher equipped with a fusual automatic closing between the kitcher equipped with a fusual automatic closing between the kitcher equipped with a fusual automatic closing between the kitcher equipped with a fusual door would close at release of a fusible available for review time of record review agreed that annual in documentation for the available for review.  These findings were Director, the Mainter	PA 80 5.2.1 states fire door inspected and tested not less a written record of the signed and kept for inspection 80, 5.2.3.1 states functional and window assemblies shall dividuals with knowledge and e operating components of ng subject to testing. NFPA re door assemblies shall be from both sides to assess the redoor assembly. This deficient at over 20 residents, staff and Dining Room.  Ons with the Maintenance eld Maintenance Supervisor facility from 1:00 p.m. to 3:25 he metal rolling fire door and main Dining Room was sible link for self-closing or ut annual inspection and on to ensure the rolling steel atomatically upon activation or link or detector was not a. Based on interview at the saw, the Maintenance Director inspection and testing the rolling steel door was not					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 12/02/2024 155757 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7510 ROSEGATE DR ROSEGATE VILLAGE INDIANAPOLIS, IN 46237 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE K 0914 **NFPA 101** SS=D Electrical Systems - Maintenance and Bldg. 01 Based on record review, observation and K 0914 12/18/2024 How will you identify other interview; the facility failed to ensure 1 of over 6 residents having the potential to nonhospital-grade electrical receptacles in be affected by the same deficient resident sleeping Room 103 were maintained in practice and what corrective action accordance with NFPA 99, Health Care Facilities will be taken? Code. NFPA 99, 2012 Edition, Section 6.3.3.2.4 Residents in room103 states the retention force of the grounding blade have the potential to be affected of each electrical receptacle (except locking-type by the alleged deficient practice. receptacles) shall be not less than 115 grams (4 All receptacles in residents rooms oz.). NFPA 70, The National Electrical Code, 2011 were checked by the maintenance Edition, at Article 517.18(B) states each patient director to ensure proper retention bed location shall be provided with a minimum of force. four receptacles. They shall be permitted to be of the single, duplex, or quadruplex type, or any What measures will be put into combination of the three. All receptacles, whether place or what systemic changes four or more, shall be listed "hospital grade" and you will make to ensure that the so identified. It is not intended that there be a deficient practice does not recur? total, immediate replacement of existing Receptacles will be non-hospital grade receptacles. It is intended, reviewed during maintenance however, that non-hospital grade receptacles be rounds. replaced with hospital grade receptacles upon modification of use, renovation, or as existing How the corrective action(s) will be receptacles need replacement. This deficient monitored to ensure the deficient practice could affect 2 residents and staff in practice will not recur. i.e., what resident sleeping Room 103. quality assurance program will be put into place? Findings include: Life Safety QA tool will be utilized weekly x 4 weeks, Based on review of "Receptacle Testing" monthly x 6 months, and quarterly documentation dated 06/24/24 with the thereafter for one year with results Maintenance Director and the Field Maintenance reported to the Quality Assurance Supervisor during record review from 9:05 a.m. to and Performance Improvement 12:30 p.m. on 12/02/24, no deficiencies were noted Committee overseen by the for annual electrical receptacle testing in resident **Executive Director** sleeping Room 103. Based on observations with If a threshold of 95% is the Maintenance Director and the Field not achieved, an action plan will Maintenance Supervisor during a tour of the be developed to ensure

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	01	COMPLETED
		155757	B. WING		12/02/2024
NAME OF P	PROVIDER OR SUPPLIER	2		ADDRESS, CITY, STATE, ZIP COD	
ROSEGA	TE VILLAGE			ROSEGATE DR NAPOLIS, IN 46237	
	_			T	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA	COMPLETION DATE
TAG		.m. to 3:25 p.m. on 12/02/24, the	IAG	compliance	DATE
		de electrical receptacle in the		Compliance	
		t box for two electrical			
		next to the wall mounted quad			
	-	outlet box for the resident bed nearest the corridor			
	door in resident slee	eping Room 103 was found to			
		orce when tested with the			
		orce testing device. The			
	-	tested with an Ideal Industries			
	-	e which found no resistance to			
	-	g device after insertion for			
	-	ring issues such as an open al. The Maintenance Director			
	-	cility's retention testing device			
		ro retention force. Based on			
	_	e of the observations, the			
		tor indicated there must have			
	been a change to the	e receptacle after 06/24/24			
	testing and agreed to	he aforementioned electrical			
	receptacle now fails	s retention force testing.			
	Those findings were	e reviewed with the Executive			
		enance Director and the Field			
		visor during the exit			
	conference.				
	3.1-19(b)				
K 0920	NFPA 101				
SS=D		ent - Power Cords and			
Bldg. 01	Extens				
Ü	Based on observation	on and interview, the facility	K 0920	What corrective action(s) will	be 12/18/2024
	failed to ensure 1 of	f 1 extension cords including		accomplished for those reside	
		ot used as a substitute for		found to have been affected b	
	-	19.5.1 requires utilities to		deficient practice?	
		n 9.1. LSC 9.1.2 requires		Maintenance Director	
	_	d equipment to comply with		immediately corrected the cor	
		Electrical Code, 2011 Edition.		during survey. Staff and resid	
		00.8 requires that, unless		education provided. Label ad	aea
	specifically permitte	ed, flexible cords and cables		to power strip.	

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155757		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 12/02/2024	
NAME OF I	PROVIDER OR SUPPLIE	2			ADDRESS, CITY, STATE, ZIP COD		
					OSEGATE DR		
ROSEGA	ATE VILLAGE			INDIAN	IAPOLIS, IN 46237		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		s a substitute for fixed wiring of			How will you identify other		
		ection 4.5.7 states any building			residents having the potential		
		or safeguard provided for life			be affected by the same defic		
	safety shall be designed, installed and approved				practice and what corrective a	ction	
	in accordance with all applicable NFPA standards.				will be taken?	:1:4	
	NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion				All residents of the fact     bever the percential to be effect.	-	
					have the potential to be affect by the alleged deficient praction		
	of a health care facility wherein patients are intended to be examined or treated. Patient care				Maintenance director checked		
		as a space, within a location			power strips to ensure approp		
	1	amination and treatment of			usage.	nate	
	patients, extending 6 ft (1.8 m) beyond the normal				Staff educated on the proper of	ISE	
	location of the bed, chair, table, treadmill, or other				of power strips.	100	
	device that supports the patient during						
	examination and treatment. A patient care vicinity				What measures will be put int	0	
		o 7 ft 6 in. (2.3 m) above the			place or what systemic chang		
	floor. NFPA 99, Se	ection 10.4.2.3 states household			you will make to ensure that the		
	or office appliances	s not commonly equipped with			deficient practice does not red	ur?	
	grounding conducte	ors in their power cords shall			Label added to power stri	p.	
	be permitted provide	led they are not located within			Maintenance Director or		
		inity. This deficient practice			designee will review that power	er	
		ents, staff and visitors in			strips do not have medical		
	resident sleeping R	oom 406.			equipment plugged in along w		
					non medical items via QA tool	/	
	Findings include:				rounds and observation for		
					continued compliance.		
		ons with the Maintenance					
		eld Maintenance Supervisor				•11	
	_	facility from 1:00 p.m. to 3:25			How the corrective action(s)	VIII	
	_	cell phone charging cable and			be monitored to ensure the	_	
		rator were plugged into a on the floor within one foot of			deficient practice will not recu	,	
		arest the window in resident			i.e., what quality assurance	2	
		5. The UL listing of the power			<ul><li>program will be put into place</li><li>Life Safety QA tool will</li></ul>		
		Based on interview at the time of			utilized weekly x 4 weeks,	ı DC	
	_	ne Maintenance Director			monthly x 6 months, and quar	terly	
	· ·	p was being used in the patient			thereafter for one year with re		
		CREE and non-PCREE and was			reported to the Quality Assura		
		a substitute for fixed wiring in			and Performance Improvement		
	_	resident sleeping room.			Committee overseen by the		

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

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155757	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  CERRET ADDRESS CHEV STATE ZIR COD		COMPI	(X3) DATE SURVEY COMPLETED 12/02/2024	
NAME OF PROVIDER OR SUPPLIER  ROSEGATE VILLAGE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE			STREET ADDRESS, CITY, STATE, ZIP COD 7510 ROSEGATE DR INDIANAPOLIS, IN 46237				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES OF TH	LD BE	(X5) COMPLETION DATE	
	Director, the Mainte	e reviewed with the Executive enance Director and the Field visor during the exit		Executive Director			

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