STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155757		IDENTIFICATION NUMBER	(X2) MULTIP A. BUILDIN B. WING	LE CONSTRUCTION IG 00	COMPI	(X3) DATE SURVEY COMPLETED 01/15/2025		
NAME OF PROVIDER OR SUPPLIER ROSEGATE VILLAGE			751	STREET ADDRESS, CITY, STATE, ZIP COD 7510 ROSEGATE DR INDIANAPOLIS, IN 46237				
(X4) ID PREFIX TAG F 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAC	CROSS-REFERENCED TO THE APP	JLD BE	(X5) COMPLETION DATE		
Bldg. 00	IN00449628 and IN Complaint IN00449 allegations are cited Complaint IN00450 related to the allegal F610. Survey date: Januar Facility number: 01 Provider number: 1 AIM number: 2008 Census Bed Type: SNF/NF: 112 SNF: 18 Total: 130 Census Payor Type Medicare: 25 Medicaid: 81 Other: 24 Total: 130 These deficiencies is accordance with 41	2628 - No deficiencies related to l. 2012 - Federal/State deficiencies tions are cited at F600 and 29 15, 2025 1149 55757 29340 : reflect State Findings cited in 0 IAC 16.2-3.1. apleted January 21, 2025.	F 0000	This plan of correction of this facility's written alleg compliance for the deficicited. The submission of of correction is not an admi or agreement with the defor conclusions contained in Indiana Department of Hinspection Report. Rosegate respective of this plan of correction in post survey revisit.	ation of encies this plan assion of eficiencies the ealth's etfully or a desk			
Bldg. 00		and record review, the facility resident's right to be free from	F 0600	What corrective action(s) accomplished for those r		02/07/2025		

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

TITLE

(X6) DATE

Tara McGlothlin HFA Executive Director 02/03/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined the 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 disclosed 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: GROL11 Facility ID: 011149 If continuation sheet Page 1 of 5

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPLETED	
		155757	B. WING			01/15/2025	
				CTREET	ADDRECC CITY CTATE ZID COD		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD OSEGATE DR		
ROSEGATE VILLAGE					OSEGATE DR IAPOLIS, IN 46237		
KUSEGA	NIE VILLAGE			INDIAN	IAFULIO, IIN 40231		
(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 APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		en a CNA spit in a resident's			found to have been affected b	by the	
		dents reviewed for abuse.			deficient practice?		
	(Resident B, CNA	1)			Social Services or		
					designee followed up for		
	Findings include:				psychosocial well being. Res		
					no longer at facility as he exp	ired	
		a.m., the Director of Nursing			on 1/12/25		
	\ / I	copy of a facility reportable			Employee was suspende		
		23/24. A review of the incident			immediately pending investig		
	report indicated CN	NA 1 spit in Resident B's face.			Employee no longer employe	ed at	
	7E1 1''' 1	6 D 11 (D 1 1			facility.		
		for Resident B was reviewed					
		a.m. The diagnoses included,			How will you identify other		
		d to, stress compression			residents having the potential		
		nbar vertebrae and chronic			be affected by the same defic		
	obstructive pulmon	nary disorder.			practice and what corrective	action	
	A Onomto of the Mr.	Data Sat (MDS)			will be taken?	_	
		num Data Set (MDS)			All residents have the particular to be affected.	ie	
	· ·	1/7/25, indicated Resident B			potential to be affected		
	was severely cogni	пусту ппрапец.			IDT interviewed all interviewable regidents that be	.0.40	
	During an interview	w on 1/15/25 at 9:35 a.m., the			interviewable residents that h		
	_	cated, on 12/23/24 at			been on CNAs assignment. N	NU	
		5 p.m., Licensed Practical Nurse			other allegations of abuse identified.		
		to report that CNA 1 spit at			Licensed nurse		
	` ′	was terminated after the			conducted skin assessments	on	
	investigation was c				all non interviewable resident		
	mresugation was c	omprowa.			that CNA's assignment. No a		
	During an interview	w on 1/15/25 at 9:58 a.m., LPN 1			of concern identified	41000	
	_	B was being aggressive and			or someon identified		
		ff, so LPN 1 and three CNA's			What measures will be put in	to	
		's room to try to provide care.			place or what systemic chang		
		ent B slapped CNA 1 in the face.			you will make to ensure that t	•	
	_	o redirect Resident B, then			deficient practice does not re		
	_	CNA 1's face. At that time, CNA			Social Services and		
	•	and spit back in Resident B's			Staff Development Coordinat		
		liately removed CNA 1 from			inservice all staff on abuse		
	Resident B's room.	-			prevention by 2/7/25.		
					IDT will interview resider	nts	
	During an interview	w on 1/15/25 at 10:15 a.m., CNA			during CARE rounds to ensur		

STATEMENT OF DEFICIENCIES X1) PROVID		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED		
	155757 B. WING			01/15/2	2025			
NAME OF PROVIDER OR SUPPLIER ROSEGATE VILLAGE				STREET ADDRESS, CITY, STATE, ZIP COD 7510 ROSEGATE DR INDIANAPOLIS, IN 46237				
NOOLOA	TE VILLAGE			INDIANAPOLIS, IN 40237				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
	CNA 1 walked to the had to go home becaface.	at the nurse's station when he nurse's station and said she he ause she spit in Resident B's a.m., the Administrator			concerns with staff treatment. concerns will be reported immediately to the Executive Director. How the corrective action(s) v	,		
1		CNA 1's written statement,			be monitored to ensure the			
		eview of the written statement A 1 was providing care to			deficient practice will not recur i.e., what quality assurance	,		
		nt B spit in CNA 1's face. CNA			program will be put into place?	?		
	-	ent B. CNA 1 "lost it" for a			Ongoing compliance			
	minute.				with this corrective action will I monitored through the facility	oe		
		a.m., the Administrator			Quality Assurance and			
		LPN 1's written statement, eview of the written statement			Performance Improvement Program (QAPI). The ED or			
		N 1 was assisting with Resident			designee will be responsible for	or		
	B's care, Resident B spit in CNA 1's face. At that time, CNA 1 said "oh no way" and spit back in Resident B's face.				completing the "Abuse Prohibi			
					and Investigation" QA tool wee times 4 weeks, monthly times	-		
	resident B's lace.				months and then quarterly x 2			
		An Employee Communication Form, dated			quarters. The results of these			
	· ·	CNA 1 spit at Resident B. CNA and the incident occurred. CNA			audits will be reviewed by the QAPI committee overseen by	the		
	1 was notified by phone that the abuse allegation was substantiated and CNA 1 was terminated for				ED. If threshold of 95% is not			
					achieved an action plan will be			
	violating the resider	nt abuse policy.			developed to ensure complian	ce.		
		a.m., the DON provided a copy dated 6/2023, titled Abuse						
		ing, and Investigation, and						
	indicated this was tl	he current policy used by the						
	1	f the policy indicated it was the						
	an environment that	y to provide each resident with						
	This citation relates	to Complaint IN00450012.						
	3.1-27(a)(1)							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GROL11 Facility ID: 011149

If continuation sheet Page 3 of 5

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPL	COMPLETED	
155757		155757	B. WING			01/15/2025	
			<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					OSEGATE DR		
ROSEGATE VILLAGE					IAPOLIS, IN 46237		
	1		1				(V.F.)
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	` ·		TAG		CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
F 0610		LSC IDENTIFYING INFORMATION		IAU			DATE
SS=D	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation						
Bldg. 00	investigate/Prever	I/Correct Alleged Violation					
Diag. 00	Raced on interview	and record review, the facility	F 06	(10	What corrective action(s) will be	20	02/07/2025
		abuse policy and ensure an	1 00	010	accomplished for those reside		02/07/2023
		of abuse was immediately			found to have been affected by		
		acility for 1 of 3 allegations of			deficient practice?	y 1110	
	abuse reviewed. (Cl				Resident no longer at	ŧ	
					facility as he expired on 1/12/2		
	Findings include:				Employee was suspende		
					immediately pending investiga		
	On 1/15/25 at 8:23	a.m., the Director of Nursing			Employee and longer employe		
		copy of a facility reportable			facility.		
		3/24. A review of the incident					
	report indicated CN	A 1 spit in Resident B's face.					
					How will you identify other		
	During an interview	on 1/15/25 at 9:58 a.m., LPN 1			residents having the potential	to	
	indicated Resident I	B was being aggressive and			be affected by the same defici	ent	
	combative with staf	f, so LPN 1 and three CNA's			practice and what corrective a	ction	
	went in Resident B'	s room to try to provide care.			will be taken?		
	-	nt B slapped CNA 1 in the face.			All residents have the		
	-	redirect Resident B, then			potential to be affected.		
	_	CNA 1's face. At that time, CNA			IDT interviewed all		
		and spit back in Resident B's			interviewable residents that ha		
		iately removed CNA 1 from			been on CNAs assignment. N	lo	
		LPN 1 went to the employee			other allegations of abuse		
		he Administrator and CNA 1			identified.		
		om, which was not in sight of			Licensed nurse		
		en LPN 1 got to the nurse's			conducted skin assessments of		
		walking out of the restroom.			all non interviewable residents	on	
		1 to write a statement then			that CNA's assignment. No		
		the facility. LPN 1 did not			areas of concern identified.		
	_	ter they left Resident B's room			\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	_	
		turned to the nurse's station			What measures will be put into		
	and UNA I Walked	out of the restroom.			place or what systemic change		
	Duning on intermi	on 1/15/25 at 10:15 a CNIA			you will make to ensure that the		
	-	on 1/15/25 at 10:15 a.m., CNA at the nurse's station when			deficient practice does not rec	ur?	
		at the nurse's station when he nurse's station and said she			Social Services and		
		ause she spit in Resident R's			Social Services and Staff Development Coordinate	r will	

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

PRINTED: 02/11/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		a. building <u>00</u>		COMPLETED	
155757		B. WING		01/15/2025	
				<u> </u>	
NAME OF PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD		
DOSEC/	ATE VILLAGE		OSEGATE DR		
RUSEGA	ATE VILLAGE	INDIAN	IAPOLIS, IN 46237		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	face. CNA 2 did not see CNA 1 at any point after		inservice all staff on abuse po	licy	
	she spit in Resident B's face until CNA 1 walked		by 2/7/25.		
	to the nurse's station.		Executive Director or		
			designee will review abuse po	olicy	
	On 1/15/25 at 8:23 a.m., the DON provided a copy		at bi-monthly all staff meeting	s	
	of a facility policy, dated 6/2023, titled Abuse		starting 3/12/25.		
	Prohibition, Reporting, and Investigation, and				
	indicated this was the current policy used by the		How the corrective action(s)	will	
	facility. A review of the policy indicated any staff		be monitored to ensure the		
	member implicated in the alleged abuse will be		deficient practice will not recu	r,	
	removed from the facility at once.		i.e., what quality assurance		
			program will be put into place	?	
	This citation relates to Complaint IN00450012.		Ongoing compliance		
			with this corrective action will	be	
	3.1-28(d)		monitored through the facility		
			Quality Assurance and		
			Performance Improvement		
			Program (QAPI). The ED or		
			designee will be responsible f	or	
			completing the "Abuse Prohib	ition	
			and investigation" QA tool we	ekly	
			times 4 weeks, monthly times	3	
			months and then quarterly x 2	2	
			quarters. The results of these		
			audits will be reviewed by the		
			QAPI committee overseen by	the	
			ED. If threshold of 95% is not	t	
			achieved an action plan will be	e	
			developed to ensure compliar	nce.	

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