STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155757	A. BUILDING 00 B. WING	01/15/2025

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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00449628 and IN00450012. Complaint IN00449628 - No deficiencies related to allegations are cited. Complaint IN00450012 - Federal/State deficiencies related to the allegations are cited at F600 and F610. Survey date: January 15, 2025 Facility number: 011149 Provider number: 155757 AIM number: 200829340 Census Bed Type: SNF/NF: 112 SNF: 18 Total: 130 Census Payor Type: Medicare: 25 Medicaid: 81 Other: 24 Total: 130 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 21, 2025.	F 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 review of this plan of correction in lieu of post survey revisit.	
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect Based on interview and record review, the facility failed to protect the resident's right to be free from	F 0600	What corrective action(s) will be accomplished for those residents	02/07/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tara McGlothlin	HFA Executive Director	02/03/2025

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	physical abuse when a CNA spit in a resident's face for 1 of 3 residents reviewed for abuse. (Resident B, CNA 1) Findings include: On 1/15/25 at 8:23 a.m., the Director of Nursing (DON) provided a copy of a facility reportable incident, dated 12/23/24. A review of the incident report indicated CNA 1 spit in Resident B's face. The clinical record for Resident B was reviewed on 1/15/25 at 8:54 a.m. The diagnoses included, but were not limited to, stress compression fracture of first lumbar vertebrae and chronic obstructive pulmonary disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 1/7/25, indicated Resident B was severely cognitively impaired. During an interview on 1/15/25 at 9:35 a.m., the Administrator indicated, on 12/23/24 at approximately 9:15 p.m., Licensed Practical Nurse (LPN) 1 called her to report that CNA 1 spit at Resident B. CNA 1 was terminated after the investigation was completed. During an interview on 1/15/25 at 9:58 a.m., LPN 1 indicated Resident B was being aggressive and combative with staff, so LPN 1 and three CNA's went in Resident B's room to try to provide care. During care Resident B slapped CNA 1 in the face. LPN 1 attempted to redirect Resident B, then 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. LPN 1 immediately removed CNA 1 from Resident B's room. During an interview on 1/15/25 at 10:15 a.m., CNA		found to have been affected by the deficient practice? • Social Services or designee followed up for psychosocial well being. Resident no longer at facility as he expired on 1/12/25 Employee was suspended immediately pending investigation. Employee no longer employed at facility. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? • All residents have the potential to be affected • IDT interviewed all interviewable residents that have been on CNAs assignment. No other allegations of abuse identified. • Licensed nurse conducted skin assessments on all non interviewable residents on that CNA's assignment. No areas of concern identified What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • Social Services and Staff Development Coordinator will inservice all staff on abuse prevention by 2/7/25. IDT will interview residents during CARE rounds to ensure no	

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	2 indicated she was at the nurse's station when CNA 1 walked to the nurse's station and said she had to go home because she spit in Resident B's face. On 1/15/25 at 10:20 a.m., the Administrator provided a copy of CNA 1's written statement, dated 12/23/24. A review of the written statement indicated when CNA 1 was providing care to Resident B, Resident B spit in CNA 1's face. CNA 1 spit back at Resident B. CNA 1 "lost it" for a minute. On 1/15/25 at 10:20 a.m., the Administrator provided a copy of LPN 1's written statement, dated 12/23/24. A review of the written statement indicated while LPN 1 was assisting with Resident 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. An Employee Communication Form, dated 12/24/24, indicated CNA 1 spit at Resident B. CNA 1 statement confirmed the incident occurred. CNA 1 was notified by phone that the abuse allegation was substantiated and CNA 1 was terminated for violating the resident abuse policy. On 1/15/25 at 8:23 a.m., the DON provided a copy of a facility policy, dated 6/2023, titled Abuse Prohibition, Reporting, and Investigation, and indicated this was the current policy used by the facility. A review of the policy indicated it was the policy of the facility to provide each resident with an environment that is free from abuse. This citation relates to Complaint IN00450012. 3.1-27(a)(1)		concerns with staff treatment. Any concerns will be reported immediately to the Executive Director. 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? • Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED or designee will be responsible for completing the “Abuse Prohibition and Investigation” QA tool weekly times 4 weeks, monthly times 3 months and then quarterly x 2 quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation Based on interview and record review, the facility failed to follow the abuse policy and ensure an alleged perpetrator of abuse was immediately removed from the facility for 1 of 3 allegations of abuse reviewed. (CNA 1) Findings include: On 1/15/25 at 8:23 a.m., the Director of Nursing (DON) provided a copy of a facility reportable incident, dated 12/23/24. A review of the incident report indicated CNA 1 spit in Resident B's face. During an interview on 1/15/25 at 9:58 a.m., LPN 1 indicated Resident B was being aggressive and combative with staff, so LPN 1 and three CNA's went in Resident B's room to try to provide care. During care Resident B slapped CNA 1 in the face. LPN 1 attempted to redirect Resident B, then 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. LPN 1 immediately removed CNA 1 from Resident B's room. LPN 1 went to the employee break room to call the Administrator and CNA 1 walked to the restroom, which was not in sight of the break room. When LPN 1 got to the nurse's station CNA 1 was walking out of the restroom. LPN 1 asked CNA 1 to write a statement then escorted her out of the facility. LPN 1 did not supervise CNA 1 after they left Resident B's room until after LPN 1 returned to the nurse's station and CNA 1 walked out of the restroom. During an interview on 1/15/25 at 10:15 a.m., CNA 2 indicated she was at the nurse's station when CNA 1 walked to the nurse's station and said she had to go home because she spit in Resident B's	F 0610	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Resident no longer at facility as he expired on 1/12/25. Employee was suspended immediately pending investigation. Employee and longer employed at facility. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected. • IDT interviewed all interviewable residents that have been on CNAs assignment. No other allegations of abuse identified. • Licensed nurse conducted skin assessments on all non interviewable residents on that CNA's assignment. No areas of concern identified. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • Social Services and Staff Development Coordinator will	02/07/2025

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	face. CNA 2 did not see CNA 1 at any point after she spit in Resident B's face until CNA 1 walked to the nurse's station. On 1/15/25 at 8:23 a.m., the DON provided a copy of a facility policy, dated 6/2023, titled Abuse Prohibition, Reporting, and Investigation, and indicated this was the current policy used by the facility. A review of the policy indicated any staff member implicated in the alleged abuse will be removed from the facility at once. This citation relates to Complaint IN00450012. 3.1-28(d)		inservice all staff on abuse policy by 2/7/25. Executive Director or designee will review abuse policy at bi-monthly all staff meetings starting 3/12/25. 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? • Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED or designee will be responsible for completing the “Abuse Prohibition and investigation” QA tool weekly times 4 weeks, monthly times 3 months and then quarterly x 2 quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	