

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155757	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/15/2025
NAME OF PROVIDER OR SUPPLIER  Rosegate Village		STREET ADDRESS, CITY, STATE, ZIP CODE  7510 Rosegate Dr Indianapolis, IN 46237	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>44849</p> <p>Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse when a CNA spit in a resident's face for 1 of 3 residents reviewed for abuse. (Resident B, CNA 1)</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>A Quarterly Minimum Data Set (MDS) assessment, dated 1/7/25, indicated Resident B was severely cognitively impaired.</p> <p>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.</p> <p>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.</p> <p>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 face.</p> <p>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.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>This citation relates to Complaint IN00450012.</p> <p>3.1-27(a)(1)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>44849</p> <p>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)</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>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 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.</p> <p>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.</p> <p>This citation relates to Complaint IN00450012.</p> <p>3.1-28(d)</p>		