

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  11/01/2024
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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>38466</p> <p>Based on interview and record review, the facility failed to ensure that written Notice of Transfer and Discharge was provided to the resident and resident's representative for 3 of 3 residents reviewed for written transfer and discharge notification. The transfer and bed-hold appeal process was not provided to the resident or the resident representative. (Resident 42, Resident 107, Resident 279)</p> <p>Findings include:</p> <p>1. On 10/30/24, at 4:30 p.m., Resident 42's clinical record was reviewed. The diagnoses included, but were not limited to, fractured femur (thighbone) and Alzheimer's disease.</p> <p>The face sheet indicated Resident 42 had a resident representative.</p> <p>The Significant Change Minimum Data Set (MDS) assessment, dated 10/21/24, indicated Resident 42 was severely cognitively impaired.</p> <p>The clinical record's census tab indicated Resident 42 was transferred to the hospital emergency department on 10/11/24.</p> <p>The ASC Hospital-ER (emergency room ) Transfer Form document, dated 10/11/24, indicated Resident 42 was transferred to the hospital emergency department for a facility-initiated hospital transfer on 10/11/24 at 9:15 a.m. The document also indicated the following:</p> <ul style="list-style-type: none"> <li>-The resident representative was notified of Resident 42's condition, reason for transfer, and location of transfer.</li> <li>-The resident and the resident representative were provided the transfer form and the bed-hold policy.</li> <li>-The transfer form lacked specific details regarding the appeal rights, process, and contact information related to the bed-hold policy.</li> </ul> <p>2. On 10/29/24 at 11:29 a.m., Resident 107's clinical record was reviewed. The diagnoses included, but were not limited to, fractured femur (thighbone) and Alzheimer's disease.</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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The face sheet indicated Resident 107 had a resident representative.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 8/6/24, indicated Resident 107 was severely cognitively impaired.</p> <p>The clinical record's census tab indicated Resident 107 was transferred to the hospital emergency department on 4/26/24.</p> <p>The ASC Hospital-ER (emergency room ) Transfer Form document, dated 4/26/24, indicated Resident 107 was transferred to the hospital emergency department for a facility-initiated hospital transfer on 4/26/24 at 12:00 p.m. The document also indicated the following:</p> <ul style="list-style-type: none"> <li>-The resident representative was notified of Resident 107's condition, reason for transfer, and location of transfer.</li> <li>-The resident and the resident representative were provided with the transfer form and the bed-hold policy.</li> <li>-The transfer form lacked specific details regarding the appeal rights, process, and contact information related to the bed-hold policy.</li> </ul> <p>3. On 10/29/24, at 11:29 a.m., Resident 279's clinical record was reviewed. The diagnoses included, but were not limited to, malnutrition, COPD (Chronic Obstructive Pulmonary Disease), and persistent postprocedural fistula (a fistula that stems from an abscess or infection).</p> <p>The face sheet indicated Resident 279 had a resident representative.</p> <p>The New Admission Minimum Data Set (MDS) assessment, dated 10/20/24, indicated Resident 279 was cognitively intact.</p> <p>The clinical record's census tab indicated Resident 279 was transferred to the hospital emergency department on 10/17/24.</p> <p>The ASC Hospital-ER (emergency room ) Transfer Form document, dated 10/17/24, indicated Resident 279 was transferred to the hospital emergency department for a facility-initiated hospital transfer on 10/17/24 at 9:57 a.m. The document also indicated the following:</p> <ul style="list-style-type: none"> <li>-The resident representative was notified of Resident 279's condition, reason for transfer, and location of transfer.</li> <li>-The resident and the resident representative were provided with the transfer form and the bed-hold policy.</li> <li>-The transfer form lacked specific details regarding the appeal rights, process, and contact information related to the bed-hold policy.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/30/24 at 1:01 p.m., Resident 279 and his representative indicated on 10/17/24 the resident was transferred to the hospital. The facility informed them of the transfer; however, no written documentation of the transfer or the bed-hold policy was provided to them.</p> <p>During an interview on 10/31/24 at 11:18 a.m., the Director of Nursing Services (DNS) indicated Resident 42, Resident 107 and Resident 279 were facility-initiated transfers to the hospital emergency department. The ASC Hospital-ER Transfer Form document was provided to the residents and their resident representatives. The transfer document included the bed-hold policy; but lacked the following appeal process information:</p> <ul style="list-style-type: none"> <li>- The name, address (mail and email), telephone number of the State entity which receives such appeal hearing requests.</li> <li>- Information on how to obtain an appeal form.</li> <li>- Information on obtaining assistance in completing and submitting the appeal hearing request.</li> <li>- The name, address (mailing and email), and phone number of the representative of the Office of the State Long-Term Care Ombudsman.</li> </ul> <p>3.1-12(a)(9)(D)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>45292</p> <p>Based on interview and record review, the facility failed to ensure complete and accurate documentation for 2 of 21 residents reviewed. (Resident B, Resident C)</p> <p>Findings include:</p> <p>1. On 10/28/24 at 10:00 a.m., the clinical record of Resident C was reviewed. The diagnoses included, but were not limited to, end stage renal disease, myocardial infarction (a heart attack), COPD (a lung disease causing breathing difficulties), and dependence on renal dialysis (treatment that removes excess fluid, waste, and toxins from the blood).</p> <p>A physician's order report, dated for active orders for 10/1/24 through 10/31/24 included, but was not limited to:</p> <p>An order with a start date of 10/19/24 and a discontinued date of 10/20/24, to obtain a daily weight for Resident C with special instructions to notify MD (Medical Doctor) of a weight gain of three pounds in one day or of five pounds in a week once a day at 5:00 a.m.</p> <p>An order with a start date of 10/20/24 and no end date to obtain a daily weight for Resident C with special instructions to notify MD (Medical Doctor) of a weight gain of three pounds in one day or of five pounds in a week once a day on the 6:30 a.m. through 2:30 p.m. shift.</p> <p>A review of resident's vitals indicated a weight recorded for Resident C on 10/19/24 of 236 pounds.</p> <p>Resident C's record lacked documentation of any other recorded weights.</p> <p>During an interview the DON (Director of Nursing) indicated that the weights should have been obtained and recorded in the electronic healthcare record daily as ordered.</p> <p>36746</p> <p>2. On 10/30/24 at 9:45 a.m., the clinical record of Resident B was reviewed. The diagnoses, included but were not limited to, disorders of bone density and structure, and osteopenia.</p> <p>A Hospice Note, dated 9/26/24 at 10:25 a.m., indicated bruising and pallor of the right lower extremity. Stat (immediate) x-ray ordered for bruising along entire right shin and knee.</p> <p>On 10/30/24 at 10:33 a.m., the Administrator provided a State Reportable Incident, dated 9/27/24. The reportable indicated during routine care, staff noted a new on-set of bruising to Resident B's right lower leg. Root cause determined to be osteopenic bones as well as chair positioning. The facility reportable indicated Resident B had bumped her leg on the table in the dining room.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Physicians Progress Note, dated 9/30/24 at 12:10 p.m., indicated a fracture of upper end of right tibia, traumatic bruising of multiple sites of the lower extremity. Resident B was frail with generalized osteoarthritis of multiple sites.</p> <p>A Care Plan, dated 8/10/20, indicated Resident B was at risk for skin break down. The interventions included but were not limited to, assess and document skin condition weekly and as needed.</p> <p>Resident B's clinical record lacked documented weekly skin assessments for 9/16/24, 9/23/24, and 9/30/24.</p> <p>During an interview on 10/30/24 at 1:33 p.m., the Director of Nursing indicated the weekly skin assessments should have been documented in the residents clinical record.</p> <p>On 10/31/24 at 1:11 p.m., the Administrator provided a policy titled Documentation Guidelines for Nursing, dated July, 2024, and indicated it was the current policy being used by the facility. A review of the policy indicated Purpose: To accurately document in an organized manner all information related to the resident in the medical record.</p> <p>This Federal tag relates to Complaint IN00444626.</p> <p>3.1-50(a)(1)</p> <p>3.1-50(a)(2)</p>		