

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/15/2016
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NAME OF PROVIDER OR SUPPLIER ROSEGATE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN 46237
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K 0000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/15/16</p> <p>Facility Number: 011149 Provider Number: 155757 AIM Number: 200829340</p> <p>At this Life Safety Code survey, Rosegate Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 150 and a</p>	K 0000		

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

TITLE

(X6) DATE

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.

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K 0130 SS=E Bldg. 01	<p>census of 139.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review on 08/18/16 - DA</p> <p>NFPA 101 MISCELLANEOUS Miscellaneous</p> <p>List in the REMARKS sections, any items that are not listed previously, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.THER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review, observation, interview; the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure.</p>	K 0130	<p>K130- NFPA 101 Miscellaneous</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>·Although there were no identified residents forthe alleged deficient practice, the following corrective action was taken. Life Safety NFPA 80 1999, requires allhorizontal or vertical sliding and rolling fire doors to be inspected andtested annually to check for proper operation and closure. Integrated Electronic Incorporated wasimmediately contacted to inspect the release mechanism of 1 of 1 horizontal orvertical sliding</p>	08/17/2016			

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	<p>Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect 30 residents, staff and visitors in the Main Dining Room.</p> <p>Findings include:</p> <p>Based on record review with the Administrator, Maintenance Director and the Administrator in Training from 8:35 a.m. to 10:45 a.m. on 08/15/16, documentation of facility rolling fire door inspection within the most recent twelve month period was not available for review. Based on observation with the Administrator, Maintenance Director and the Administrator in Training during a tour of the facility from 10:45 a.m. to 2:20 p.m. on 08/15/16, the facility has one rolling fire door protecting the opening from the kitchen to the Main Dining Room and had no inspection documentation within the most recent twelve month period affixed to the rolling door. The Main Dining Room is not open to the corridor. Based on interview on at the time of observation, the Administrator and the Maintenance Director acknowledged documentation of an annual inspection or test to check for</p>		<p>and rolling fire doors. This inspection occurred on Wednesday, August 17, 2016 with no deficient findings.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>·Although there were no identified residents for the alleged deficient practice, this deficient practice could affect 30 residents, staff and visitors in the Main Dining Room. In order to correct the deficient practice the necessary inspection for 1 of 1 horizontal or vertical sliding and rolling fire doors to check for proper operation and closure of the release mechanism. Wednesday, August 17, 2015. Inspection report attached for supporting documentation.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>·Maintenance director will follow the requirements for participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 401 IAC 156.2 and schedule the inspection in his preventative maintenance log to</p>	

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	proper operation and full closure of the rolling fire door within the most recent twelve month period was not available for review. 3.1-19(b)		<p>ensure compliance.</p> <ul style="list-style-type: none"> ·Executive Director will in-service the Maintenance Director by August 17, 2014 on the requirements for participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 401 IAC 156.2 · The Maintenance Director will report to the Safety Committee Meeting monthly, overseen by the Executive Director, the due date for the vertical sliding and rolling fire door inspection to check for proper operation and closure. <p>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?</p> <ul style="list-style-type: none"> ·Maintenance Director will monitor this item in the preventative maintenance log provided by American Senior Communities. ·The Executive Director will collect and monitor the preventative maintenance log and audits will be completed monthly X 12 months. ·If threshold of 100% is not achieved, an action plan will be developed to achieve desired threshold. Data will be submitted 	

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			to the CQI committee for review and follow up. Effective Date of Compliance: 8/17/2016		