

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 04/28/2014
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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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K010000	<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: 04/28/14</p> <p>Facility Number: 011149 Provider Number: 155757 AIM Number: 200829340</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</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 census of 138.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p>	K010000	Rosegate Village respectfully requests desk review in lieu of an onsite visit.	

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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K010029 SS=F	<p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/01/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following: NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 13 of 18 doors serving hazardous areas such as fuel fired heater rooms, soiled linen rooms, trash collection rooms, laundries and storage rooms used to store combustible materials which are greater than 100 square feet in size; each have a 3/4-hour fire protection rating. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 11:20 a.m. to 2:20 p.m. on 04/28/14, the following was noted: a. the Mechanical Rooms inside the 100, 200, 300 and 400 Hall Laundry Services rooms each had a natural gas fired furnace in the room and the entry door had a 20 minute fire resistance rating label affixed to the door. b. the 100, 200, 300 and 400 Hall Laundry Services rooms were each being used to</p>	K010029	<p>K029- NFPA 101 Life Safety Code Standards</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Facility placed an order on April 30, 2014 for One Hour Fire Rated Doors for the following rooms: Mechanical Rooms and the Laundry services room for the 100, 200, 300, 400, 500 Halls, Maintenance shop, Mechanical Room on Service Hallway and Soiled & Clean Laundry room doors on the service hallway. Orders are scheduled to arrive between May 7th – 10th. Doors will be installed by May 12.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective</p>	05/14/2014

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	<p>store 32 gallons or more of soiled linen and trash and the entry doors from the corridor each had a 20 minute fire resistance rating label affixed to the door.</p> <p>c. the 500 Hall Mechanical Room had a natural gas fired furnace in the room and the entry door from the corridor had a 20 minute fire resistance rating label affixed to the door.</p> <p>d. the Maintenance Shop measured greater than 100 square feet in size, was being used as a combustible supply storage room and the entry door from the service corridor had a 20 minute fire resistance rating label affixed to the door.</p> <p>e. the Mechanical Room at the service corridor had three natural gas fired water heaters in the room and the entry door from the corridor had a 20 minute fire resistance rating label affixed to the door.</p> <p>f. the entry door from the corridor to the Soiled Laundry room and the entry door from the corridor to the Clean Laundry room which was over 100 square feet in size, each had a 20 minute fire resistance rating label affixed to the door.</p> <p>Based on interview at the time of the observations, the Executive Director and the Maintenance Director acknowledged each of the aforementioned hazardous area's entry doors had a 20 minute fire resistance rating label affixed to the door.</p> <p>3.1-19(b)</p>		<p>action will be taken?</p> <ul style="list-style-type: none"> All residents have the potential to be affected by this alleged practice. All hazardous rooms have the potential to be affected by the alleged deficient practice. As the The Life Safety Code agent toured the building with ED and Maintenance Director, the agent identified doors that needed replacement. No other doors were identified needing replacement. <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> <ul style="list-style-type: none"> Upon installation of the One Hour Fire Rated Doors, the deficient practice should not recur. No construction is planned for 2014 that would affect any doors. <p>How will the corrective action be monitored to ensure the deficient practice will not occur?</p> <ul style="list-style-type: none"> The doors are scheduled to be replaced and after they are installed the deficient practice will not occur. 	

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K010050 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the third shift for 3 of 4 quarters. This deficient practice affects all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Monthly Fire Drill Report" documentation with the Maintenance Director during record review from 9:10 a.m. to 11:20 a.m. on 04/28/14, third shift fire drills conducted on 09/27/13, 12/27/13 and 03/30/14 were conducted, respectively, at 4:05 a.m., 5:00 a.m. and 4:45 a.m. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned third shift fire drills were not conducted at unexpected times under varying conditions.</p> <p>3.1-19(b)</p>	K010050	<p>K050- NFPA 101 Life Safety Code Standards What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Life Safety requires that fire drills be performed one time per shift per quarter. A fire drill will be held on third shift at an unexpected time between the hours of 11:00pm – 1:00AM on or before May 14, 2014. The start time for the fire drills held on the same shift must vary by at least 2 hours from one drill to the next. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · Although there were no identified residents for the alleged deficient practice, all residents have the potential to be affected by this deficient practice. A fire drill will be held on third shift at an unexpected time between the hours of 11:00PM – 1:00AM on or before May 14, 2014. What</p>	05/14/2014

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			<p>measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Maintenance director will follow the "Fire Drill – Shift/ Time Stagger" log provided by American Senior Communities. · Executive Director will in-service the Maintenance Director by May 6, 2014 on the Fire Drill Safety-Shift/Time Schedule Stagger policy to ensure compliance. · The Maintenance Director will report to the Executive Director after the Safety Committee Meeting , overseen by the Executive Director, on a monthly basis the time and date of the previous fire drill. · The Maintenance Director will maintain a log and copy will be submitted to CQI Committee monthly. 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? · Maintenance director will follow the "Fire Drill – Shift/ Time Stagger" log provided by American Senior Communities. · The Executive Director will collect and maintain the log Fire Drill –Shift/Time Stagger on a monthly basis. Audits will be completed weekly X 4 weeks, monthly X 2 months, and quarterly thereafter for at least two quarters. · If threshold of 95% is not achieved, an action plan will be developed to achieve</p>	

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K010144 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. NFPA 99, Health Care Facilities, 3-4.1.1.4 requires generator sets installed as alternate power sources shall meet the requirements of NFPA 110, Standard for Emergency Standby Power Systems. NFPA 110, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break glass station located elsewhere on the premises where the prime mover is located outside the building. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Maintenance Director during a tour of the facility from 11:20 a.m. to 2:20 p.m. on 04/28/14, a remote shut off device was not found for the emergency generator. Based on interview at the time of observation, the Maintenance Director stated the emergency generator is rated at 50 kW and had '05 stamped on the engine block. The battery charger affixed to the unit had a manufacture date of 10/21/05. At 2:35 p.m. on 4/28/14, the emergency generator was manually started and when the "push to end"</p>	K010144	<p>desired threshold. Data will be submitted to the CQI committee for review and follow up.</p> <p>K144- NFPA 101 Life Safety Code Standards</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 for the alleged deficient practice, the following corrective action was taken. On April 27, 2014 a Remote Emergency Generator Shut Off Valve was professionally installed.</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>· All residents have the potential to be affected. There is only one generator for the facility and the Remote Emergency Generator Shut Off Valve was installed.</p> <p>·</p> <p>What measures will be put into place or what systemic changes</p>	05/14/2014

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	<p>button was depressed at the transfer switch the emergency generator continued to run in a cool down mode. Based on interview at the time of observation, the Executive Director stated the emergency generator was installed in 2005 or later and acknowledged the emergency generator was not equipped with a remote shut off device.</p> <p>3.1-19(b)</p>		<p>you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> The Remote Emergency Generator Shut Off Valve was installed, the deficient practice should not recur. <p>How will the corrective action be monitored to ensure the deficient practice will not occur?</p> <ul style="list-style-type: none"> The Remote Emergency Generator Shut Off Valve is installed, the deficient practice should not recur. 	