

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 02/08/2012
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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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K0000	<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: 02/08/12</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, resident rooms and all areas not separated from the corridor. The facility has a capacity of 150 and a census of 139.</p>	K0000	Please accept this 2567 Plan of Correction for the Life Safety Survey ending February 8, 2012 as the Provider's Letter of Credible Allegation. This Provider respectfully requests a Post Survey Revisit on or after March 9, 2012.	
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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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	<p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/13/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			
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K0029 SS=E	<p>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 2 of 14 doors serving hazardous areas such as the kitchen are provided with a positive latching device to latch each door into the door frame. This deficient practice could affect any resident, staff or visitor in the vicinity of the kitchen entry door from the Main Dining Room and the kitchen entry door from the 500 Hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 1:40 p.m. to 4:00 p.m. on 02/08/12, a latch was not provided for the kitchen entry door from the Main Dining Room or for the kitchen entry door from the 500 Hall. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the kitchen entry door from the Main Dining Room and the kitchen entry door from the 500 Hall are each not equipped with a positive latching device to latch each door into the door frame.</p>	K0029	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to have any negative outcomes by the findings. 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 by the finding. All doors serving hazardous areas were immediately checked to ensure positive latching devices are present. Positive latching hardware was installed on the kitchen entry door from the Main Dining Room and for the kitchen entry door from the 500 hall. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? 14 of 14 doors serving hazardous areas are now provided with a positive latching device. As part of the ongoing facility preventative maintenance program, the Maintenance Director will inspect weekly all doors serving hazardous areas for proper</p>	03/09/2012			

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	3.1-19(b)		closure and operation and service if needed. 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? The Executive Director will review the Preventative Maintenance Log to ensure compliance with required hazardous areas door inspections weekly X 4 weeks, monthly X 2 months and quarterly thereafter. Results of the audit will be presented to the CQI Committee monthly to ensure compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action.		

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K0038 SS=F	<p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1</p> <p>Based on observation and interview, the facility failed to ensure 6 of 6 exit door electromagnetic locks remained unlocked while the fire alarm was activated. LSC 18.2.1 requires every aisle, passageway, corridor, exit discharge, exit location, and access to be in accordance with Chapter 7. LSC 7.2.1.6.2(e) states activation of the building automatic sprinkler or fire detection system, if provided, automatically unlocks the doors and the doors remain unlocked until the fire-protective signaling system has been manually reset. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during a tour of the facility from 1:40 p.m. to 4:00 p.m. on 02/08/12, the electromagnetic locks on all six exit doors did not release and remain unlocked when the fire alarm was activated at 3:31 p.m. Based on interview at the time of the observations, the Maintenance Supervisor acknowledged the electromagnetic locks at exit doors should have released and remained unlocked at each of the six building exits</p>	K0038	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to have any negative outcomes by the findings. 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 by the finding. A service call was immediately conducted by our alarm system vendor and repairs made. The alarm system was tested at that time and all exit doors unlocked when the alarm system was activated. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The electromagnetic locks on all six exit doors now release and remain unlocked when the fire alarm system is activated. As part of the ongoing facility preventative maintenance program, the Maintenance Director conducts a monthly test of the fire alarm system including a check to ensure that all magnetic locking exit doors release upon activation. How the corrective action (s) will be monitored to ensure the</p>	03/09/2012			

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	when the fire alarm was activated. 3.1-19(b)		deficient practice will not recur, i.e., what quality assurance program will be put into place? The Maintenance Director will activate the alarm system to ensure exit doors automatically unlock weekly X 2 and monthly thereafter. The Executive Director reviews the completed Preventative Maintenance log monthly ongoing. Results of the audit will be presented to the CQI Committee monthly to ensure compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action.		

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K0039 SS=E	<p>Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes is at least 8 feet. In limited care facilities and psychiatric hospitals, width of aisles or corridors is at least 6 feet. 18.2.3.3, 18.2.3.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 6 exit access corridors had a clear and unobstructed exit width of at least 8 feet (96 inches). This deficient practice could affect any resident, staff or visitor if needing to exit the facility from the service corridor in the 500 Hall in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 1:40 p.m. to 4:00 p.m. on 02/08/12, twelve lockers, one bed and one chest of drawers were being stored in the service corridor in the 500 Hall. The service corridor in the 500 Hall is marked as an exit and the unobstructed width of the service corridor in the 500 Hall measured eight feet wide. The twelve lockers protruded 15 inches into the service corridor and the storage of the bed and chest of drawers also served to decrease the exit corridor width from eight feet. Based on interview at the time of observation, the Maintenance Supervisor stated the service corridor in</p>	K0039	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to have any negative outcomes by the findings. 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 by the finding. The lockers, bed and chest of drawers were immediately removed from the 500 hall service corridor to provide an unobstructed exit. All other exit access corridors within the facility were immediately inspected to ensure each had a clear and unobstructed exit width of at least 8 feet. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? 6 of 6 exit access corridors now have a clear and unobstructed exit width of at least 8 feet. An inservice will be completed by the Maintenance Director to all staff regarding maintaining appropriate exit access corridor requirements.</p>	03/09/2012
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	<p>the 500 Hall is marked as an emergency exit and acknowledged the lockers, bed and chest of drawers decreased the unobstructed width of the service corridor in the 500 Hall to less than eight feet.</p> <p>3.1-19(b)</p>		<p>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? A CQI audit tool will be used by the Executive Director and/or designee to conduct facility rounds to monitor compliance with maintaining width requirements for corridors serving as exit access weekly X 4 weeks, monthly X 2 months and quarterly thereafter. Results of the audit will be presented to the CQI Committee monthly to ensure compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action.</p>	

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K0144 SS=C	<p>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 record review and interview, the facility failed to ensure monthly load test documentation for the emergency generator was at least 30% of the nameplate rating for 8 of 12 months. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator-Weekly Exercise/Monthly</p>	K0144	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to have any negative outcomes by the findings. 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 by the finding. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? An inservice will be completed by a corporate maintenance consultant to the facility Maintenance Director regarding requirements for monthly generator load testing and documentation. As part of the ongoing facility preventative maintenance program, the Maintenance Director will conduct and document monthly generator load tests. The Executive Director reviews the completed Preventative Maintenance log monthly ongoing. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance</p>	03/09/2012	

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	<p>Load Test Log" with the Maintenance Supervisor from 9:20 a.m. to 12:00 p.m. on 02/08/12, the monthly load testing logs for the period of May 2, 2011 through December 12, 2011 show the emergency generator ran for at least thirty minutes each month for the eight month period but the percentage of load capacity under "actual reading under load" was recorded the same as the "load test end time meter recording." The operating temperature during monthly load testing was not included on monthly load test documentation. Based on interview at the time of observation, the Maintenance Supervisor stated the facility does not perform an annual load bank test and acknowledged monthly load testing documentation for the eight month period from May 2, 2011 through December 12, 2011 did not include the actual load percentage of the nameplate rating for the emergency generator under "actual reading under load."</p> <p>3.1-19(b)</p>		<p>program will be put into place? The Executive Director will review the Preventative Maintenance Log to ensure compliance with required generator inspections weekly X 4 weeks, monthly X 2 months and quarterly thereafter. Results of the audit will be presented to the CQI Committee monthly to ensure compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action.</p>	

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K0147 SS=E	<p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 extension cords was not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect any resident, staff or visitor in the vicinity of the Assistant Director of Nursing's Office.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 1:40 p.m. to 4:00 p.m. on 02/08/12, a microwave oven was plugged into one extension cord in the Assistant Director of Nursing's Office. Based on interview at the time of observation, the Maintenance Supervisor and the Assistant Director of Nursing acknowledged an extension cord was in use for the microwave oven in the Assistant Director of Nursing's Office.</p> <p>3.1-19(b)</p>	K0147	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to have any negative outcomes by the findings. 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 by the finding. The microwave oven and extension cord were immediately removed from the Assistant Director of Nursing's office. Rounds were immediately conducted to ensure that no other extension cords were being used within the facility. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? An inservice will be completed by the Maintenance Director to all staff regarding not using extension cords as substitutes for fixed wiring within the facility. 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? A CQI audit tool will be used by the Executive Director and/or</p>	03/09/2012
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			designee to conduct facility rounds to monitor compliance with extension cords not being used within the facility as a substitute for fixed wiring weekly X 4 weeks, monthly X 2 months and quarterly thereafter. Results of the audit will be presented to the CQI Committee monthly to ensure compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action.	

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K0154 SS=F	<p>Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and staff interview, the facility failed to provide a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1 in order to protect 139 of 139 residents. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, the Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire Watch Policy and Procedure" documentation with the</p>	K0154	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to have any negative outcomes by the findings. 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 by the finding. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The facility "Fire Watch Policy and Procedure" has been revised to require notification of the Indiana State Department of Health, the local fire department, facility insurance carrier, facility alarm company and building owner/manager in the event that the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period. The Executive Director and/or designee will inservice the Maintenance Director, Director of Nursing Services, Assistant</p>	03/09/2012			

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	<p>Maintenance Supervisor and the Executive Director (ED) during record review from 1:00 p.m. to 1:40 p.m. on 02/08/12, Procedure 6 states "Call 911 to report the fire. The facility's ED or designee will notify all necessary entities." The facility's written fire watch policy stated the necessary entities, which includes the Indiana State Department of Health, alarm company, local fire department, and building owner/manager, would only be notified in the event of a fire. Based on interview at the time of observation, the ED and the Maintenance Supervisor stated the facility's written fire watch policy requires notification only in the event of a fire and acknowledged the written fire watch policy does not state notification of the Indiana State Department of Health, alarm company, local fire department, and building owner/manager in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period.</p> <p>3.1-19(b)</p>		<p>Director of Nursing Services and charge nurses regarding the revised fire watch policy. The facility disaster manual(s) will be updated to include the revised fire watch policy. 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? The Executive Director will review all circumstances requiring initiation of a fire watch to ensure compliance with notification for all required entities. Results of the review will be presented to the CQI Committee to ensure compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action.</p>	

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 02/08/2012
NAME OF PROVIDER OR SUPPLIER ROSEGATE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN 46237		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
K0155 SS=F	<p>Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and staff interview, the facility failed to provide a complete written policy containing procedures to be followed in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8 in order to protect 139 of 139 residents. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire Watch Policy and Procedure" documentation with the Maintenance Supervisor and the Executive Director (ED) during record review from 1:00 p.m. to 1:40 p.m. on 02/08/12, Procedure 6 states "Call 911 to report the fire. The facility's ED or designee will notify all necessary entities." The facility's written fire watch policy stated the authority having jurisdiction, the Indiana State Department of Health and the local fire department would only be notified in the event of a fire. Based on interview at the time of</p>	K0155	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to have any negative outcomes by the findings. 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 by the finding. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The facility "Fire Watch Policy and Procedure" has been revised to require notification of the Indiana State Department of Health, the local fire department, facility insurance carrier, facility alarm company and building owner/manager in the event that the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period. The Executive Director will inservice the Maintenance Director, Director of Nursing Services, Assistant Director of Nursing</p>	03/09/2012	

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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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	<p>observation, the ED and the Maintenance Supervisor stated the facility's written fire watch policy requires notification only in the event of a fire and acknowledged the written fire watch policy does not state notification of the Indiana State Department of Health and local fire department would occur in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period.</p> <p>3.1-19(b)</p>		<p>Services and charge nurses regarding the revised fire watch policy. The facility disaster manual(s) will be updated to include the revised fire watch policy. 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? The Executive Director will review all circumstances requiring initiation of a fire watch to ensure compliance with notification for all required entities. Results of the review will be presented to the CQI Committee to ensure compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action.</p>	