

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2014
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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374
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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: 02/26/14</p> <p>Facility Number: 000135 Provider Number: 155230 AIM Number: 100266820</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Rosebud 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 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of type V (000) construction and was fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery operated smoke</p>	K010000	<p>This Plan of Correction constitutes the centers Allegation of Compliance. The following Plan of Correction is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparation and execution of this response and the Plan of Correction does not constitute an admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law.</p>	

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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K010027 SS=E	<p>detectors in all resident sleeping rooms. The facility has a capacity of 110 and had a census of 94 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled except the main entrance porch overhang. All areas providing facility services were sprinkled.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/04/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 3 of 8 sets of smoke barrier doors would restrict the</p>	K010027	K027 What corrective action will takeplace for those residents found	03/14/2014			

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	<p>movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires that doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect 44 residents who reside on the A Hall and B Hall.</p> <p>Findings include:</p> <p>Based on observations on 02/26/14 during a tour of the A Hall and B Hall from 11:40 a.m. to 12:45 p.m. with the maintenance supervisor, the A Hall set of smoke barrier doors, the A Hall Station 1 to Station 2 set of smoke barrier doors, and the B Hall set of smoke barrier doors each lacked self closing devices. Furthermore, when the doors were released manually from the magnetic hold down devices, the doors failed to move and left the doors open eight feet wide, which was the width of each corridor. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 02/26/14 at 1:45 p.m.</p>		<p>to be affected by the deficient practice? No residents wereaffected.</p> <p>How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action will be taken? 44 residents had the potential to beaffected. Maintenance Director ensuredthat the 3 sets of smoke barrier doors have self closing devices and complywith the regulation.</p> <p>What measures will be put into placeor what systemic changes will be made to ensure that the deficient practicedoes not reoccur? ExecutiveDirector provided in-service to Maintenance Director on the NFPA 101 LifeSafety Code Standard.</p> <p>How will the correctiveactions be monitored to ensure they do not occur again? A CQI monitoringtool will be completed by Maintenance Director weekly times four weeks and thenmonthly times 2 months and quarterly times 1 to total at least six months. Audit tools will be submitted to the CQIcommittee and action plans will be developed as needed if the threshold of 95%is not met.</p> <p>By what date will the changesoccur?</p>		

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K010029 SS=E	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 12 hazardous area, such as a laundry room over 100 square feet in size, was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice affects 14 residents who reside on the Station 1 Hall, near the laundry room.</p> <p>Findings include:</p> <p>Based on observation on 02/26/14 at 10:50 a.m. with the maintenance supervisor, the Station 1 Hall laundry room door, which opened into the Service Hall, had a self closing device which did not allow the door to self close and latch, leaving a two inch gap</p>	K010029	<p>3/14/2014</p> <p>K029 What corrective action will takeplace for those residents found to be affected by the deficient practice? No residents were affected. How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action will be taken? 14 residents had the potential to beaffected. Maintenance Director ensuredthat the door equipped with a self closing device shuts completely in to thedoor frame and complies with the regulation. What measures will be put into placeor what systemic changes will be made to ensure that the deficient practicedoes not reoccur? ExecutiveDirector provided in-service to Maintenance Director on the NFPA 101</p>	03/14/2014			

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K010038 SS=E	<p>with the door in the "closed" position. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 02/26/14 at 1:45 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 4 of 10 exit door electromagnetic lock remained unlocked while the fire alarm was activated and silenced. LSC 19.2.1 requires every aisle, passageway, corridor, exit discharge, exit location, and access to be in accordance with Chapter 7. LSC 7.2.1.6.2 requires, where permitted in Chapters 11 through 42, doors in the means of egress shall be permitted to be equipped with an approved entrance and egress access control system, provided that the following criteria are met. (d) Activation of the building fire-protective signaling system, if provided, shall automatically unlock the doors in the</p>	K010038	<p>LifeSafety Code Standard. How will the correctiveactions be monitored to ensure they do not occur again? A CQI monitoringtool will be completed by Maintenance Director weekly times four weeks and thenmonthly times 2 months and quarterly times 1 to total at least six months. Audit tools will be submitted to the CQIcommittee and action plans will be developed as needed if the threshold of 95%is not met. By what date will the changesoccur? 3/14/2014</p> <p>K038 What corrective action will takeplace for those residents found to be affected by the deficient practice? No residents wereaffected.</p> <p>How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action will be taken? 76 residents had the potential to beaffected. Maintenance Director ensuredthat the 4 sets of electromagnetic locks on exit doors release and stayedunlocked while the fire alarm is active and comply with the regulation.</p>	03/14/2014	

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	<p>direction of egress, and the doors shall remain unlocked until the fire-protective signaling system has been manually reset. This deficient practice affects 18 residents who reside on the Station 2 Hall and 58 residents who use the main dining room.</p> <p>Findings include:</p> <p>Based on observations during a test of the fire alarm system on 02/26/14 with the maintenance supervisor from 1:15 p.m. to 1:40 p.m., the electromagnetic lock on the two main dining room exit doors, the Station 2 exit door and the Service Hall exit door failed to release and unlock when the fire alarm was activated, and stayed locked when the fire alarm was silenced but not reset. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 02/26/14 at 1:45 p.m.</p> <p>3.1-19(b)</p>		<p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? Executive Director provided in-service to Maintenance Director on the NFPA 101 Life Safety Code Standard.</p> <p>How will the corrective actions be monitored to ensure they do not occur again? A CQI monitoring tool will be completed by Maintenance Director weekly times four weeks and then monthly times 2 months and quarterly times 1 to total at least six months. Audit tools will be submitted to the CQI committee and action plans will be developed as needed if the threshold of 95% is not met.</p> <p>By what date will the changes occur? 3/14/2014</p>		

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K010052 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 67 smoke detectors in the facility was not installed where air flow would adversely affect its operation. Section 9.6.1.4 requires fire alarm systems comply with NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 require,s in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect 14 resident who reside on Station 1.</p> <p>Findings include:</p> <p>Based on an observation with the maintenance supervisor on 02/26/14 at 1:15 p.m., the Station 1 Hall smoke detector next to the set of smoke barrier doors near the nurses' station was located within one foot of a return air duct. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 02/26/14 at 1:45 p.m.</p>	K010052	<p>K052</p> <p>What corrective action will takeplace for those residents found to be affected by the deficient practice? No residents wereaffected.</p> <p>How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action will be taken? 14 residents had the potential to beaffected. Maintenance Director ensuredthat the 1 smoke detector located within one foot of return air duct has beenrelocated to comply with the regulation.</p> <p>What measures will be put into placeor what systemic changes will be made to ensure that the deficient practicedoes not reoccur? ExecutiveDirector provided in-service to Maintenance Director on the NFPA 101 LifeSafety Code Standard.</p> <p>How will the correctiveactions be monitored to ensure they do not occur again?</p>	03/14/2014			

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K010056 SS=E	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 combustible porch overhangs was provided with sprinkler coverage. NFPA 13, 1999 Edition, 5-13.8.1 requires sprinklers shall be installed under exterior combustible roofs or canopies exceeding four feet in width. This deficient practice could affect 44</p>	K010056	<p>A CQI monitoring tool will be completed by Maintenance Director weekly times four weeks and then monthly times 2 months and quarterly times 1 to total at least six months. Audit tools will be submitted to the CQI committee and action plans will be developed as needed if the threshold of 95% is not met.</p> <p>By what date will the changes occur? 3/14/2014</p> <p>K056 What corrective action will take place for those residents found to be affected by the deficient practice? No residents were affected.</p> <p>How other residents having the potential to be affected by the same deficient practice will be</p>	03/14/2014

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	<p>residents who reside on the A Hall and B Hall who would use the main entrance for evacuation.</p> <p>Findings include:</p> <p>Based on observation on 02/26/14 at 1:30 p.m. with the maintenance supervisor, the main entrance porch overhang had a one foot bulkhead separating the eight foot by twelve foot section of sprinkled porch overhang from the four foot by twelve foot section of nonsprinklered porch overhang connected to the facility. Furthermore, the maintenance supervisor indicated the porch overhang is constructed of wood and covered in vinyl siding. The lack of sprinkler coverage for the main entrance four foot by twelve foot section of porch overhang connected to the facility was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 02/26/14 at 1:45 p.m.</p> <p>3.1-19(b)</p>		<p>identified and what corrective action will be taken? 44 residents had the potential to be affected. Maintenance Director ensured that the entire eight foot by twelve foot section of porch overhang is fully sprinklered and comply with the regulation.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? Executive Director provided in-service to Maintenance Director on the NFPA 101 Life Safety Code Standard.</p> <p>How will the corrective actions be monitored to ensure they do not occur again? A CQI monitoring tool will be completed by Maintenance Director weekly times four weeks and then monthly times 2 months and quarterly times 1 to total at least six months. Audit tools will be submitted to the CQI committee and action plans will be developed as needed if the threshold of 95% is not met.</p> <p>By what date will the changes occur? 3/14/2014</p>		

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K010067 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 8 of 8 egress corridors were not being used as a portion of a return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. NFPA 90A, Standard for the Installation of Air Conditioning and Ventilation Systems at 2-3.11.1 requires egress corridors shall not be used as a portion of a supply return or exhaust air system serving adjoining areas. This deficient practice affects all resident in the facility.</p> <p>Findings include:</p> <p>Based on observations on 02/26/14 during an initial tour of the facility from 9:05 a.m. to 9:35 p.m. with the administrator, all rooms in the facility used the egress corridors as a return air system. Furthermore, there were contractors in the facility installing return air ducts during the initial tour. Based on an interview with the administrator on 02/26/14 at 9:35 a.m., the return air ducts were cited on last</p>	K010067	<p>K067</p> <p>What corrective action will takeplace for those residents found to be affected by the deficient practice?</p> <p>All residents wereaffected and a new HVAC system is currently being installed in entire facilityto ensure that return air ducts are installed in all resident rooms. A waiver has been submitted to request awaiver for 120 days to complete the HVAC system install.</p> <p>How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action will be taken?</p> <p>All residents wereaffected and a new HVAC system is currently being installed in entire facilityto ensure that return air ducts are installed in all resident rooms. A waiver has been submitted to request awaiver for 120 days</p>	03/14/2014
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	<p>years' survey, and a contractor was hired to install return air ducts throughout the facility. An extension was requested last year until 03/08/14. The lack of return air ducts in all rooms in the facility was verified by the administrator at the time of observations and confirmed by the administrator at the 1:45 p.m. exit conference on 02/26/14.</p> <p>3.1-19(b)</p>		<p>to complete the HVAC system install.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? Executive Director provided in-service to Maintenance Director on the NFPA 101 Life Safety Code Standard.</p> <p>How will the corrective actions be monitored to ensure they do not occur again? A CQI monitoring tool will be completed by Maintenance Director weekly times four weeks and then monthly times 2 months and quarterly times 1 to total at least six months. Audit tools will be submitted to the CQI committee and action plans will be developed as needed if the threshold of 95% is not met.</p> <p>By what date will the changes occur? 3/14/2014</p>		