| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155523 | A. BUILDING -- B. WING | 08/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| RICHLAND BEAN BLOSSOM HEALTH CARE CENTER | 5911 STATE ROAD 46 ELLETTSVILLE, IN 47429 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (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 |
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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 08/01/24<br><br>Facility Number: 000558<br>Provider Number: 155523<br>AIM Number: 100267550<br><br>At this Emergency Preparedness survey, Richland Bean Blossom Health Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73<br><br>The facility has a capacity of 74 certified beds and had a census of 59 at the time of this visit.<br><br>Quality Review completed on 08/02/24 | E 0000 | **The facility respectfully requests paper compliance for this citation**<br>***This plan of correction is the centers credible allegation of compliance.***<br>***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.*** | |
| K 0000<br><br>Bldg. 01 | A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).<br><br>Survey Date: 08/01/24<br><br>Facility Number: 000558<br>Provider Number: 155523<br>AIM Number: 100267550<br><br>At this Life Safety Code survey, Richland Bean | K 0000 | **The facility respectfully requests paper compliance for this citation**<br>***This plan of correction is the centers credible allegation of compliance.***<br>***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the*** | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Jacqueline Routt | Executive Director | 08/15/2024 |

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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| | Blossom Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.<br><br>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hardwired smoke detectors in the corridors and spaces open to the corridors. All resident rooms were equipped with battery powered smoke alarms. The facility has the capacity for 74 residents and had a census of 59 at the time of this survey.<br><br>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except three detached buildings used for facility storage and maintenance.<br><br>Quality Review completed on 08/02/24 | | ***statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.*** | |
| K 0222<br>SS=F<br>Bldg. 01 | NFPA 101<br>Egress Doors<br>Egress Doors<br>Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements:<br>CLINICAL NEEDS OR SECURITY THREAT LOCKING<br>Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall | | | |

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| | be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.<br>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6<br>SPECIAL NEEDS LOCKING ARRANGEMENTS<br>Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.<br>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4<br>DELAYED-EGRESS LOCKING ARRANGEMENTS<br>Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.<br>18.2.2.2.4, 19.2.2.2.4<br>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS<br>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. | | | |

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| | 18.2.2.2.4, 19.2.2.2.4<br>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS<br>Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.<br>18.2.2.2.4, 19.2.2.2.4<br>Based on observation and interview, the facility failed to ensure the means of egress through 4 of the facility's exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect everyone in the facility.<br><br>Findings include:<br><br>Based on observations during a tour of the facility with the Maintenance Director on 08/01/24 between 1:24 p.m. and 2:15 p.m., the following exit doors, marked as facility exits, were magnetically locked and could be opened by entering a four-digit code but the code was not posted at the exits:<br>A) Exit by resident room 210<br>B) Therapy exit<br>C) Exit in Dining Room<br>D) Exit by MDS Coordinator office<br>Based on interviews at the time of observations, the Maintenance Director confirmed that codes were not posted at the aforementioned exit doors. | K 0222 | **K 222 Egress Doors**<br><br>1 Immediate action taken.<br>All marked exit doors have been labeled with the four-digit code.<br>2 How the facility plans to establish compliance.<br><br>A random audit of the building's egress doors has been completed to ensure that all egress doors are labeled with the exit code.<br><br>3 Measures put into place/ system changes.<br><br>A monthly facility audit has been put into place to ensure that all exit doors are labeled with the exit code. The Maintenance director or designee will randomly audit facility exit doors for proper door code labels 1 day a week x 12 weeks, then monthly x 3 months to ensure substantial compliance.<br><br>4 How the corrective action will be monitored.<br>The results of these audits will be | 08/02/2024 |

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| | This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.<br><br>3.1-19(b) | | reviewed in the Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan as indicated. | |
| K 0761<br>SS=D<br>Bldg. 01 | NFPA 101<br>Maintenance, Inspection & Testing - Doors<br>Maintenance, Inspection & Testing - Doors<br>Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.<br>Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.<br>Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.<br>Written records of inspection and testing are maintained and are available for review.<br>19.7.6, 8.3.3.1 (LSC)<br>5.2, 5.2.3 (2010 NFPA 80)<br>Based on records review and interview, the facility failed to ensure annual inspection and testing of at least 1 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, | K 0761 | **K 761 – Inspection & Testing – Doors**<br>1. Immediate action taken.<br>An inspection of the fire doors using the NFPA 80 was completed on 8/2/2024 with no findings.<br>2 How the facility plans to establish compliance.<br><br>The NFPA 80 has been added to the annual facility PM schedule. | 08/12/2024 |

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| | anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified:<br>(1) No open holes or breaks exist in surfaces of either the door or frame.<br>(2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped.<br>(3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage.<br>(4) No parts are missing or broken.<br>(5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7.<br>(6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position.<br>(7) If a coordinator is installed, the inactive leaf closes before the active leaf.<br>(8) Latching hardware operates and secures the door when it is in the closed position.<br>(9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame.<br>(10) No field modifications to the door assembly have been performed that void the label.<br>(11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity.<br>This deficient practice could affect staff. | | 3 Measures put into place/ system changes.<br><br>The NFPA 80 inspection of fire doors have been added to the annual facility PM schedule and will trigger annually for completion through the use of the TELs system.<br><br>4 How the corrective action will be monitored.<br>The annual inspection of the NFPA 80 will be reviewed in the Quality Assurance Meeting upon completion annually The QA committee will identify any trends or patterns and make recommendations to revise the plan as indicated. | |

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| | Findings include:<br><br>Based on records review with the Maintenance Director on 08/01/24 at 12:50 p.m., no documentation of an annual inspection for the Oxygen Transfilling room fire door assembly was available for review. Based on interview with the Maintenance Director, he stated that he checks all the barrier doors in the building monthly and marks the task complete in the computer based records program. The Maintenance Director stated that the oxygen room is not on the itemized listing of required fire doors. Based on observation at 1:57 p.m., the oxygen room has a 60 minute rated fire door.<br><br>This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.<br><br>3.1-19(b) | | | |
| K 0920 SS=B Bldg. 01 | NFPA 101<br>Electrical Equipment - Power Cords and Extens<br>Electrical Equipment - Power Cords and Extension Cords<br>Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In | | | |

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| | non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5<br>Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect approximately 3 staff and 7 residents.<br><br>Findings include:<br><br>Based on observations during a tour of the facility with the Maintenance Director on 08/01/24 at 1:35 p.m., a microwave was plugged into and supplied power by a power strip in the employee break room next to resident room 201. Based on interview at the time of observation, the Maintenance Director confirmed that a microwave was supplied power by a power strip. The Maintenance Director removed the power strip upon observation and plugged it into a wall outlet.<br><br>The finding was reviewed with the Executive Director and Maintenance Director at the exit conference.<br><br>3.1-19(b) | K 0920 | **K 920 Power Strip**<br>1. Immediate action taken.<br>The power strip was removed from the identified location and the microwave was plugged directly into the wall outlet.<br>2 How the facility plans to establish compliance.<br><br>A facility wide audit was completed to identify any other power strips in use with no findings.<br><br>3 Measures put into place/ system changes.<br><br>A monthly facility audit has been established to ensure that there is no improper use of power strips. The Maintenance director or designee will randomly audit 10 outlets in the facility 1 day a week x 12 weeks, then monthly x 3 months to ensure substantial compliance.<br><br>4 How the corrective action will be monitored.<br>The results of these audits will be | 08/12/2024 |

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| | | | reviewed in the Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan as indicated. | |
| K 0927<br>SS=D<br>Bldg. 01 | NFPA 101<br>Gas Equipment - Transfilling Cylinders<br>Gas Equipment - Transfilling Cylinders<br>Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99).<br>11.5.2.2 (NFPA 99)<br>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage room was provided with properly working mechanical ventilation. This deficient practice could affect 15 residents and 4 staff.<br><br>Findings include:<br><br>Based on observation made during a tour of the facility on 08/01/24 at 1:58 p.m. with the Maintenance Director, the oxygen storage room contained approximately four green oxygen cylinders and four liquid oxygen containers. There was a mechanically ventilated exhaust fan in the ceiling of this room, however, it was not working | K 0927 | **K 927 Exhaust Fan**<br>1 Immediate action taken.<br><br>The identified exhaust fam located in the oxygen transfer room was replaced on 8/6/2024 and is functioning properly.<br><br>2 How the facility identified other similar building construction non-compliance.<br><br>There are no other oxygen transfer rooms located in the facility | 08/06/2024 |

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| | at the time of observation. This was tested by holding a piece of paper up to the vent, but the vent was not working and the fan blades were observed not turning. This was confirmed by the Maintenance Director at the time of observation.<br><br>This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.<br><br>3.1-19(b) | | 3 Measures put into place/ system changes.<br><br>A weekly facility audit has been established to ensure that the fan is on and functioning properly in the oxygen transfer room. The Maintenance director or designee will randomly audit the oxygen transfer room once per week x 12 weeks, then monthly x 3 months to ensure substantial compliance. Proper function has been added to the PM check list monthly for ongoing review.<br><br>4 How the corrective action will be monitored.<br>The results of these audits will be reviewed in the Quality Assurance Meeting Annually. The QA committee will identify any trends or patterns and make recommendations to revise the plan as indicated. | |