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	05/30/2023

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/30/23 Facility Number: 000558 Provider Number: 155523 AIM Number: 100267550 At this Emergency Preparedness survey, Richland Bean Blossom Health Care Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has a capacity of 79 certified beds and had a census of 57 at the time of this visit. Quality Review completed on 06/02/23	E 0000	**The facility respectfully requests paper compliance for this citation** ***This plan of correction is the centers credible allegation of compliance.*** ***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.***	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jacqueline Routt		06/20/2023

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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	systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain			

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	the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013.			

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	(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator and Maintenance Director on 05/30/23 from 9:30 a.m. to 12:45 p.m., monthly generator load documentation was incomplete. The following was noted: a) The 12/28/22 monthly load documenation shows start time was 7:00 a.m. and end time was 7:45 a.m.. The hour meter reading start showed 357.0 and end time showed 357.1. The run time was documented as 30 minutes. b) The 01/30/23 monthly load documenation shows start time was 8:00 a.m. and end time was 9:00 a.m.. The hour meter reading start showed 358.3 and end time showed 358.3. The run time was documented as 30 minutes. c) The 02/28/23 monthly load documenation shows start time was 9:00 a.m. and end time was 10:15 a.m.. The hour meter reading start showed 360.6 and end time showed 360.6. The run time was documented as 60 minutes. Based on an interview at the time of record review, the Maintenance Director confirmed the aforementioned monthly load documentation included conflicting information. The Maintenance Director stated the meter reader at the generator does not always turn over, and he	E 0041	**E 041** 1. Immediate action taken. The company monitoring the generator function (SafeCare) was contacted and will be out within 30 days to repair the gauge on the generator. 2. How the facility identified other similar building construction non-compliance. The facility maintains the use of only 1 generator. No other areas of concern at this time. 3. Measures put into place/ system changes. A monthly facility audit has been established to monitor the proper function of the generator gauge. The Maintenance director or designee will randomly audit the generator audit 1 day a week x 12 weeks, then monthly x 3 months to ensure substantial compliance. 4. How the corrective action will be monitored. 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.	07/17/2023

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	will contact the company that services the generator for inspection. This finding was reviewed with the Administrator and Maintenance Director at the exit conference.			
K 0000 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). Survey Date: 05/30/23 Facility Number: 000558 Provider Number: 155523 AIM Number: 100267550 At this Life Safety Code survey, Richland Bean 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. 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 79 residents and had a census of 57 at the time of this survey. All areas where residents have customary access	K 0000	**The facility respectfully requests paper compliance for this citation** ***This plan of correction is the centers credible allegation of compliance.*** ***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.***	

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	were sprinklered and all areas providing facility services were sprinklered, except three detached buildings used for facility storage and maintenance. Quality Review completed on 06/02/23			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 6 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect staff if needing to exit the facility in the service hall next to the kitchen. Findings include: Based on observations and interview during a facility tour with the Maintenance Director and Administrator on 05/30/23 between 12:45 p.m. and 2:22 p.m., the exit from the service hall by the kitchen to the outside was obstructed with two vending machines which would prevent staff from accessing the public way free of all obstructions or impediments with full instant use in the case of fire or other emergency. This finding was acknowledged by the Administrator at the time of discovery and again	K 0211	**K 211 Exit door obstruction** 1. Immediate action taken. The Vending Machines have been moved to a location that does not obstruct a emergency exit. 2. How the facility plans to establish compliance. A random audit of the building's emergency exits was completed to ensure no other exits are being obstructed, no new findings at this time. 3. Measures put into place/ system changes. A monthly facility audit has been put into place to ensure that all exit doors are free of any obstruction. The Maintenance	06/16/2023

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	at the exit conference with the Administrator and Maintenance Director present. 3.1-19(b)		director or designee will randomly audit facility exits areas 1 day a week x 12 weeks, then monthly x 3 months to ensure substantial compliance. 4. How the corrective action will be monitored. The results of these audits will be 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 0222 SS=F Bldg. 01	NFPA 101 Egress Doors Egress Doors 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: CLINICAL NEEDS OR SECURITY THREAT LOCKING 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 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. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING			

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	ARRANGEMENTS 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. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS 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. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS 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			

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	approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 3 of 7 exit doors in the facility 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. LSC 7.2.1.5.3 requires if provided, locks shall not require of a key, a tool, or special knowledge or effort for operation from the egress side. This deficient practice could affect all residents and staff. Findings include: Based on observation with the Administrator and Maintenance Director on 05/30/23 between 12:45 p.m. and 2:22 p.m., the following findings were noted: a) The emergency exit doors at the main entrance was magnetically locked and required a 4-digit code. The code posted at the keypad had to be entered backwards, but that information was not posted. b) The emergency exit doors entering the service hall was magnetically locked and required a 4-digit code but was not posted at the exit. c) The emergency exit doors entering Memory Care was magnetically locked and required a 4-digit code but was not posted at the exit. Based on interview at the time of observations, the Administrator and Maintenance Director agreed the codes to the doors were not posted nor clearly marked.	K 0222	**K 222 – Egress Doors** 1. Immediate action taken. The words "enter code backwards" along with the 4 digit code where posted at the main entrance, emergency exit entering the service hall, and upon entering the memory care unit. 2. How the facility plans to establish compliance. The words "enter code backwards" along with the 4 digit code where posted at the main entrance, emergency exit entering the service hall, and upon entering the memory care unit. 3. Measures put into place/ system changes. A monthly facility audit has been established to ensure the means of egress through exit doors in the facility are readily accessible. The Maintenance director or designee will randomly audit the Egress doors in the facility 1 day a week x 12 weeks, then monthly x 3 months to ensure substantial compliance. 4. How the corrective action will be monitored. The results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or	06/16/2023

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	These findings were reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		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 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on record review and interview; the facility failed to install exit signage on 1 of 1 exterior door in the Activities Room in accordance with LSC 7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect as many as 25 residents, 4 staff, and 2 visitors. Findings include: Based on observation made during a tour of the facility with the Administrator and the Maintenance Director on 05/30/23 from 12:45 p.m. to 2:22 p.m., the exterior door to the outside in the	K 0293	**K 293 Exit Signage** 1. Immediate action taken. A temporary sign was placed on the exit door on 5/30/23. Permanent signage was ordered and was placed upon arrival on 6/17/23. The Signage reads “not an exit” 2. How the facility plans to establish compliance. A facility audit off all exit doors was conducted to ensure Exit directional signs are displayed in accordance with 7.10. no other findings were identified at this time. 3. Measures put into place/ system changes.	06/17/2023

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	Activities Room was not marked as a facility Exit or Not an Exit. Based on interview at the time of observation, the Maintenance Director stated the keypad access corridor door to Activities Room is normally kept closed and confirmed the exterior door in the Activities Room was not identified as an Exit or Not An Exit. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		A monthly facility audit has been established to ensure that all exit doors are labeled in accordance to 7.10. The Maintenance director or designee will randomly audit the exit doors in the facility 1 day a week x 12 weeks, then monthly x 3 months to ensure substantial compliance. 4. How the corrective action will be monitored. The results of these audits will be 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 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview; the facility failed to ensure all battery-operated smoke alarms in resident rooms were maintained. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, Section 29.10 states fire-warning equipment shall be maintained and	K 0300	**K 300 Protection – Other** 1. Immediate action taken. The facility was placed on a fire watch for precautionary measures in the event that the expired smoke detector did not function as manufactured to do so. New	06/08/2023

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	tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. Section 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observation during a tour of the facility from 12:45 p.m. to 2:22 p.m. with Administrator and Maintenance Director on 05/30/23, the battery-operated smoke detector mounted in resident room #204 was inspected. The smoke detector was manufactured on February 8, 2012 and was more than 10 years old. Based on interview at the time of the above-mentioned observation, the Maintenance Director stated he was unaware of the manufactured date of the single action smoke alarm and would check every battery operated smoke alarms in the resident rooms for manufacture date and replace if necessary. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(c)		smoke detectors were immediately ordered and installed on 6/8/2023 upon arrival. 2. How the facility identified other similar building construction non-compliance. A random audit was conducted of the battery-operated smoke detectors. All battery-operated smoke detectors have been replaced. The manufacturer recommends replacing the smoke detector 10 years following the printed date of 2/2023. 3. Measures put into place/ system changes. A random annual audit of battery-operated smoke detectors will be completed by the maintenance director or designee to ensure a timely replacement. The audit will be reviewed by the facility Quality Assurance committee annually. 4. How the corrective action will be monitored. 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155523	A. BUILDING 01 B. WING	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 of 8 hazardous areas such as mechanical room and shower rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing	K 0321	**K 321 – Hazardous Areas – Enclosure** 1. Immediate action taken.	06/02/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155523	A. BUILDING 01 B. WING	05/30/2023

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	or automatic closing in accordance with LSC 7.2.1.8. This deficient practice could affect 20 residents and staff in two smoke compartments. Findings include: Based on observation with the Administrator and Maintenance Director during a tour of the facility from 12:45 p.m. to 2:22 p.m. on 05/30/23, the following was observed: a) the corridor door to the Mechanical room in the service hall was equipped with a self-closing device but the door failed to fully close and latch into the door frame as it caught on a rug. The Mechanical Room contained fuel fired equipment. The Administrator removed the rug from the service hall corridor at the time of observation. b) the corridor door to the small shower room by the nurse station failed to close and latch into the frame when tested three times. The room measured approximately 70 square feet and contained combustible storage. Based on interview at the time of observations, the Maintenance Director confirmed the corridor doors to the aforementioned hazardous areas failed to self-close and latch into the door frame. These findings were reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		The rug preventing the door from closing was immediately removed. Once removed the door was able to properly close and latch into the door frame. 2. How the facility identified other similar building construction non-compliance. A facility wide audit of all hazardous areas secured by doors was conducted to ensure all doors are able to properly function without obstruction, no other concerns where identified at this time. 3. Measures put into place/ system changes. A monthly facility audit has been established to ensure that hazardous areas secured by doors are observed for obstruction. The Maintenance director or designee will randomly audit hazardous areas 1 day a week x 12 weeks, then monthly x 3 months to ensure substantial compliance. 4. How the corrective action will be monitored. 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	

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	155523	A. BUILDING 01 B. WING	05/30/2023

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

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			plan as indicated.	
K 0331 SS=D Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). Based on observation and interview, the facility failed to ensure materials used as an interior finish on 1 of 1 Laundry had a flame spread rating of Class A or Class B in accordance with 19.3.3.1. LSC 3.3.90.4 defines interior wall finish as the interior finish of columns, fixed or movable walls, and fixed or movable partitions. A.3.3.90.2 states interior finish is not intended to apply to surfaces within spaces such as those that are concealed or inaccessible. This deficient practice could affect staff in the Laundry. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 05/30/23 between 12:45 p.m. and 2:22 p.m., the Laundry had approximately a 1'X8' hole in the drywall along the floor exposing the wood studs behind. The facility was unable to provide interior finish documentation for a flame spread classification of Class A or B for the aforementioned interior exposed finish. Based on interview with the Maintenance Director at the time of observation,	K 0331	**K 331 Interior Wall and Ceiling Finish** 1. Immediate action taken. The dry wall covering the hole in the laundry room was replaced and finished in accordance to 19.3.3.1. 2. How the facility identified other similar building construction non-compliance. A random facility audit for potential hazards related to interior wall and ceiling finishes completed, no other concerns where identified at this time. 3. Measures put into place/ system changes. A monthly facility audit has been	06/16/2023

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	155523	A. BUILDING 01 B. WING	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	he confirmed the drywall was missing along the floor in the Laundry room, exposing the wood studs. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		established for interior wall and ceiling finish compliance. The Maintenance director or designee will randomly audit interior wall and ceiling finishes 1 day a week x 12 weeks, then monthly x 3 months to ensure substantial compliance. 4. How the corrective action will be monitored. 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.	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13,			

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	Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) 1. Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 1 of 1 storage room in accordance with 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect up to 10 residents and two staff. Findings include: Based on observation with the Administrator and Maintenance Director on 05/30/23 from 12:45 p.m. to 2:22 p.m., the storage room room resident room 407 had storage touching or within three inches of the ceiling. Based on interview at the time of observation, the Administrator stated the the boxes stored in the room were COVID tests and PPE supplies and confirmed the boxes were stored up to the ceiling and would rearrange the materials within the closet. 2. Based on observation and interview, the facility failed to maintain the ceiling construction in the facility in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the	K 0351	**K 351 – Sprinkler System Installation** 1. Immediate action taken. As of 5/30/23 All stored items have been relocated to maintain proper clearance for the sprinkler system. The escutcheon was re secured. 2. How the facility identified other similar building construction non-compliance. A random facility audit for further identification of obstructed sprinkler heads and missing/ loose escutions was completed, all other areas of concerns have been addressed to meet compliance. 3. Measures put into place/ system changes. A monthly facility audit has been established to identify obstructed clearance for sprinkler heads. The Maintenance director or designee will randomly audit facility storage areas and escutcheons 1 day a week x 12 weeks, then monthly x 3 months to ensure substantial compliance.	06/23/2023

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	annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff and up to 20 residents and staff in three smoke compartments. Findings include: Based on observation with the Administrator and the Maintenance Director on 05/30/23 from 12:45 p.m. to 2:22 p.m., the following was noted: a) resident room 104 and soioled utility in 400 hall had missing escutcheons b) resident room 309 had an escutcheon that was falling down from the ceiling Based on interview at the time of each observation, the Maintenance Director confirmed the escutcheons were either missing or had fallen down from the ceiling. These findings were discussed with the Administrator and Maintenance Director at exit conference. 3.1-19(b)		4. How the corrective action will be monitored. 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.	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on observation and interview, the facility failed to ensure 1 of 1 therapy rooms was not open to the corridor. LSC 19.3.6.1(a) does not permit spaces such as patient sleeping rooms, treatment rooms, and hazardous areas to be open	K 0361	**K 361 Areas Open to Corridors** 1. Immediate action taken. Appropriate latching hardware was installed to the double doors that	06/23/2023

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	to the corridor LSC 19.3.6.3 requires patient sleeping rooms, treatment rooms, and hazardous areas to be provided with positive latching doors. This deficient practice could affect staff and up to 5 residents in the therapy gym. Findings include: Based on observation with the Maintenance Director and Administrator on 05/30/23 from 12:45 p.m. to 2:22 p.m. during a tour of the facility, the set of double doors entering the dining room and therapy gym (a treatment room) from the corridor were not provided with positive latching hardware, therefore making the therapy gym open to the corridor. Based on interview at the time of observation, the Maintenance Director and Administrator agreed the doors to the therapy gym were not equipped with any latching devices. The finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		incorporate the therapy "treatment area". 2. How the facility identified other similar building construction non-compliance. A facility audit was conducted on all areas open to corridors to ensure a functional latching system is in place, no other areas of concern were identified. 3. Measures put into place/ system changes. A monthly facility audit has been established to monitor the proper function of all corridor latching systems. The Maintenance director or designee will randomly audit the latching system for corridors 1 day a week x 12 weeks, then monthly x 3 months to ensure substantial compliance. 4. How the corrective action will be monitored. 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.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors			

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	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			

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	155523	A. BUILDING 01 B. WING	05/30/2023

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	1. Based on observation and interview, the facility failed to ensure 2 of over 40 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 15 staff and residents. Findings include: Based on observations and interviews during a tour of the facility with the Administrator and Maintenance Director on 05/30/23 between 12:45 p.m. and 2:22 p.m., the corridor door of resident room 107 failed to close and latch positively into the door frame. Additionally, new medication carts were stored in vacant resident room 210 in such a way that the door was not able to be closed and latched unless the carts were moved. Based on interview at the time of the observations, the Maintenance Director confirmed that resident room 107 corridor door did not close and latch into the door frame. Based on interview with the Administrator at the time of observation, she agreed the medication carts were blocking the corridor door from closing. These findings were reviewed with the Administrator and Maintenance Director at the exit conference. 2. Based on observation and interview, the facility failed to ensure 1 of over 30 corridor doors would resist the passage of smoke. This deficient practice could affect 10 residents and 2 staff. Findings include: Based on observation during a tour of the facility with the Administrator and Maintenance Director 05/30/23 between 12:45 p.m. and 2:22 p.m., the	K 0363	**K 363 Corridor – Doors** 1. Immediate action taken. The door on room 107 was repaired to function as intended latching into the door frame when closed. The Medication carts from room 210 have been removed to allow proper closing function of the door. A smoke tight barrier was added to the 400 hall medication room door to ensure the resistance of smoke. 2. How the facility identified other similar building construction non-compliance. A facility audit was conducted on all areas facility doors to ensure proper smoke barrier functions can per performed in the event of a fire, no other areas of concern were identified. 3. Measures put into place/ system changes. A monthly facility audit has been established to monitor the closing function of corridor doors. of all corridor latching systems. The Maintenance director or designee will randomly audit the corridor doors in the facility 1 day a week x 12 weeks, then monthly x 3 months to ensure substantial compliance.	06/09/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155523	A. BUILDING 01 B. WING	05/30/2023

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	corridor door to the medication room at the nurse station had a half inch hole above and below the door handle, which would negate the ability of the door to be smoke tight. Based on interview at the time of observation, the Maintenance Director confirmed there were holes in the corridor door and was not smoke tight. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		4. How the corrective action will be monitored. 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.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 wall mounted electrical outlet boxes in a Clean Utility Room was protected and was not broken. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. Article 406.5, states receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect 10 residents and staff in the vicinity of the 400 Hall Clean Utility Room. Findings include: Based on observation with the Maintenance	K 0511	**K 511 Utilities – Gas and Electric** 1. Immediate action taken. Cover plate installed for identified outlet. 2. How the facility identified other similar building construction non-compliance. A random facility audit was conducted on facility outlets, with no other areas of concern identified. 3. Measures put into place/	06/09/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155523	A. BUILDING 01 B. WING	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Director during a tour of the facility from 12:45 p.m. to 2:22 p.m. on 05/30/23, the receptacle in the wall mounted outlet box near the floor in the 400 Hall Clean Utility Room was missing a cover plate which exposed the electrical wiring in the box. Based on interview at the time of observation, the Maintenance Director agreed the receptacle was not provided with a cover plate. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		system changes. A monthly facility audit has been established to monitor the intact installation of facility outlet covers. The Maintenance director or designee will randomly audit the facility outlet covers 1 day a week x 12 weeks, then monthly x 3 months to ensure substantial compliance. 4. How the corrective action will be monitored. 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.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised			

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	155523	A. BUILDING 01 B. WING	05/30/2023

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(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
	once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 3 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include:	K 0918	**E 041/ K 918** 1. Immediate action taken. The company that maintains the generator function (SafeCare) was contacted and will be out within 30 days to repair the gauge on the generator. 2. How the facility identified other similar building construction non-compliance. The facility maintains the use of only 1 generator. No other areas of concern at this time. 3. Measures put into place/ system changes.	07/17/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155523	A. BUILDING 01 B. WING	05/30/2023

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	Based on record review with the Administrator and Maintenance Director on 05/30/23 from 9:30 a.m. to 12:45 p.m., monthly generator load documentation was incomplete. The following was noted: a) The 12/28/22 monthly load documenation shows start time was 7:00 a.m. and end time was 7:45 a.m.. The hour meter reading start showed 357.0 and end time showed 357.1. The run time was documented as 30 minutes. b) The 01/30/23 monthly load documenation shows start time was 8:00 a.m. and end time was 9:00 a.m.. The hour meter reading start showed 358.3 and end time showed 358.3. The run time was documented as 30 minutes. c) The 02/28/23 monthly load documenation shows start time was 9:00 a.m. and end time was 10:15 a.m.. The hour meter reading start showed 360.6 and end time showed 360.6. The run time was documented as 60 minutes. Based on an interview at the time of record review, the Maintenance Director confirmed the aforementioned monthly load documentation included conflicting information. The Maintenance Director stated the meter reader at the generator does not always turn over, and he will contact the company that services the generator for inspection. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		A monthly facility audit has been established to monitor the proper function of the generator gauge. The Maintenance director or designee will randomly audit the generator audit 1 day a week x 12 weeks, then monthly x 3 months to ensure substantial compliance. 4. How the corrective action will be monitored. 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.	