STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155230	A. BUILDING -- B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEBUD VILLAGE	2050 CHESTER BLVD RICHMOND, IN 47374

(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: 06/20/24 Facility Number: 000135 Provider Number: 155230 AIM Number: 100266820 At this Emergency Preparedness survey, Rosebud Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 110 certified beds. At the time of the survey, the census was 93. Quality Review completed on 06/25/24	E 0000	Dear Brenda Buroker, Attached is Rosebud Village's plan of correction for Life Safety Code with Emergency Preparedness Survey completed on 6/20/2024. Rosebud Village is requesting paper compliance for all deficiencies written in the 2567. Please accept the plan of correction as written. Thank you, Kari Alcorn, HFA Executive Director	
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: 06/20/24 Facility Number: 000135 Provider Number: 155230 AIM Number: 100266820 At this Life Safety Code survey, Rosebud Village was found not in compliance with Requirements	K 0000	Dear Brenda Buroker, Attached is Rosebud Village's plan of correction for Life Safety Code with Emergency Preparedness Survey completed on 6/20/2024. Rosebud Village is requesting paper compliance for all deficiencies written in the 2567. Please accept the plan of correction as written. Thank you, Kari Alcorn, HFA Executive Director	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kari Alcorn	Executive Director	07/08/2024

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	for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(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. This one-story facility was determined to be of type V (111) construction and was fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery-operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 110 and had a census of 93 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has one detached wooden storage building used for storage which was not sprinkled. Quality Review completed on 06/25/24			
K 0281 SS=F Bldg. 01	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 Based on interview and observation, it was determined that the facility failed to provide exterior emergency lighting for all exits. LSC Section 7.9.1.1 requires emergency lighting facilities for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect all occupants in the facility	K 0281	/b> /p> /b> All residents with access to cottage courtyard gate have the potential to be affected by the	08/08/2024

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	including staff, visitors and residents if the facility were required to evacuate in an emergency. Findings include: Based on observations and interview during a tour of the facility with the Executive Director and Maintenance Director (MD) on 06/20/24 between 12:10 p.m. and 2:15 p.m., the exit discharge path leading to the public way out of the courtyard leads to a gate with a code to exit. The area around the aforementioned gate was not illuminated so that someone could read the code and exit after dark. No lights were visible which would illuminate the path of exit discharge around the coded gate. This finding was acknowledged by the Executive Director and Maintenance Director at the time of discovery and again at the exit conference with the Executive Director and Maintenance Director present. 3.1-19(b)		alleged deficiency. Lighting was added near the cottage courtyard gate. (See attachment) The maintenance director or designee will conduct rounds to ensure the lighting is functioning correctly. Any issues will be immediately rectified. /b> Maintenance director or designee will do an audit of the facility to ensure that all exits are illuminated. Any issues will be immediately rectified. Maintenance director or designee with do a monthly walk through to ensure compliance. Executive director to monitor for compliance. /b> Maintenance director or designee with do a monthly walk through for six months to ensure compliance with results brought to QAPI for review. If a threshold of 90% is not met, an action plan will be developed to ensure compliance. Executive director to monitor for compliance. **What date will systemic changes be completed? 8/8/24**	
K 0293 SS=E	NFPA 101 Exit Signage			

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Bldg. 01	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 observation and interview; the facility failed to install directional exit signage in 1 of over 5 exits 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 staff and 18 residents on the "C" Hall. Findings include: Based on observations and interview during a tour of the facility with the Executive Director and Maintenance Director (MD) on 06/20/24 between 12:10 p.m. and 2:15 p.m., the exit door leading out of the end of the "C" Hall marked as an exit, had two paths occupants could take on the exit discharge (right and Left). One direction led back into the building before exiting the facility. The other direction led to the actual exit however it was confusing which way to go and the desired path was not obvious. The MD agreed that directional signage would be necessary for someone unfamiliar with the facility to to know which way to go.	K 0293	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The facility will clearly mark the exit path leading out of the end of “C” hallway with a sign that directs everyone to go away from the building. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents who have access to the exit path outside of “C” hallway have the ability to be affected by the alleged deficient practice. A sign was added outside the exit of “C” hallway (see attached). The maintenance director or designee will conduct rounds to ensure the sign is in place. Any issues will be immediately rectified. What measures will be put into	08/08/2024

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	This finding was acknowledged by the Executive Director and Maintenance Director at the time of discovery and again at the exit conference with the Executive Director and Maintenance Director present. 3.1-19(b)		place and what systemic changes will be made to ensure the deficient practice does not recur? Maintenance director or designee will do an audit of the facility exit paths to ensure that all exits are clearly marked with direction of exit path away from building. Any issues will be immediately rectified. Maintenance director or designee with do a monthly walk through to ensure compliance. Executive director to monitor for compliance. How the corrective action will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? Maintenance director or designee with do a monthly walk through for six months to ensure compliance with results brought to QAPI for review. If a threshold of 90% is not met, an action plan will be developed to ensure compliance. Executive director to monitor for compliance. What date will systemic changes be completed? 8/8/24	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other			

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	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. Based on observation and interview, the facility	K 0363	What corrective action will be	08/08/2024

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	failed to ensure all 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 6 staff and 15 residents. Findings include: Based on observations and interview during a tour of the facility with the Executive Director and Maintenance Director on 06/20/24 between 12:10 p.m. and 2:15 p.m., the following corridor doors failed to latch positively into their respective door frames or have no impediment to closing: a) Resident Room #50, the door was dragging on the floor. b) Resident Room #49, the door was dragging on the floor. c) Activities Area Door, with delf-closing device, failed to self-close and latch. d) The Business Office door, with delf-closing device, failed to self-close and latch. e) Housekeeping mechanical room on the Cottage hall, with self-closing device, failed to self-close and latch. f) Resident Room #40 door obstruction. g) Resident Room #32 door obstruction. h) Therapy area corridor door, obstruction. This finding was acknowledged by the Executive Director and Maintenance Director at the time of discovery and again at the exit conference with the Executive Director and Maintenance Director present. 3.1-19(b)		accomplished for those residents found to have been affected by the deficient practice? The facility removed the door obstructions for rooms 40, 32, and therapy area. The facility adjusted the doors for rooms 50 and 49, the business office, and activity area to prevent dragging. The facility will repair the self-closing latch on the cottage housekeeping mechanical room door and activity area door. The facility will remove the self-closing latch on the business office as it is no longer warranted. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents with access to rooms 32, 40, 49, 50, the business office, the activity area, and the cottage housekeeping mechanical room have the ability to be affected by the alleged deficient practice. The maintenance director or designee will conduct rounds to ensure that all doors close and latch correctly and that doors do not drag the floor, and there are no door obstructions. Any issues will be immediately rectified. What measures will be put into	

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			place and what systemic changes will be made to ensure the deficient practice does not recur? The maintenance director or designee will conduct rounds to ensure that all doors close and latch correctly and that doors do not drag the floor, and there are no door obstructions. Any issues will be immediately rectified. Any issues will be immediately rectified. Maintenance director or designee with do a monthly walk through to ensure compliance. Executive director to monitor for compliance. How the corrective action will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? Maintenance director or designee with do a monthly walk through for six months to ensure compliance with results brought to QAPI for review. If a threshold of 90% is not met, an action plan will be developed to ensure compliance. Executive director to monitor for compliance. What date will systemic changes be completed? 8/8/24	

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K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the smoke barrier ceiling in the mechanical room was protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect 3 staff.	K 0372	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The facility sealed the attic access in the mechanical room. The facility covered the access panel with material that is adequate and with fire resistance rating. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents within the same smoke barrier area of the mechanical room have the ability to be affected by the alleged deficient practice. The	08/08/2024

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	Findings include: Based on observations and interview during a tour of the facility with the Executive Director and Maintenance Director (MD) on 06/20/24 between 12:10 p.m. and 2:15 p.m., the attic access location in the mechanical room was unsealed at the time of the survey. Furthermore, the material used to cover the access did not appear adequate to cover the entire area of the ceiling penetration not have the fire resistance rating required. This finding was acknowledged by the Executive Director and Maintenance Director at the time of discovery and again at the exit conference with the Executive Director and Maintenance Director present. 3.1-19(b)		maintenance director or designee will conduct rounds to ensure that attic access is sealed and covered with adequate, fire resistance rating material. Any issues will be immediately rectified. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? The maintenance director or designee will conduct rounds to ensure that attic access is sealed and covered with adequate, fire resistance rating material. Any issues will be immediately rectified. Any issues will be immediately rectified. Maintenance director or designee with do a monthly walk through to ensure compliance. Executive director to monitor for compliance. How the corrective action will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? Maintenance director or designee with do a monthly walk through for six months to ensure compliance with results brought to QAPI for review. If a threshold of 90% is not met, an action plan will be developed to ensure compliance. Executive director to monitor for compliance.	

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			What date will systemic changes be completed? 8/8/24	
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review, observation and interview; the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) Projections into the required	K 0711	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The facility will develop a map identifying the facility's smoke compartments or firewalls. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents within the facility have the ability to be affected by	08/08/2024

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	width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 inches. (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants. Findings include: Based on observations and interview during a tour of the facility and records review with the Executive Director and Maintenance Director (MD) on 06/20/24 between 12:10 p.m. and 2:15 p.m., the written fire safety plan did not identify the facility's smoke compartments or firewalls. Based on interview at the time of review, the MD acknowledged the aforementioned written fire safety plan did not address the location of the facility's smoke compartments. The map provided only identified the location of the facility's fire extinguishers. The MD stated that they did not have a diagram showing the smoke compartments or firewalls. This finding was acknowledged by the Executive Director and Maintenance Director at the time of discovery and again at the exit conference with the Executive Director and Maintenance Director present.		the alleged deficient practice. The maintenance director or designee will conduct rounds to ensure that facility maps are present identifying smoke compartments/firewalls. Any issues will be immediately rectified. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? The maintenance director or designee will conduct rounds to ensure that facility maps are present identifying smoke compartments/firewalls. Any issues will be immediately rectified. Any issues will be immediately rectified. Maintenance director or designee with do a monthly walk through to ensure compliance. Executive director to monitor for compliance. All staff will be educated on smoke compartments/firewalls. How the corrective action will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? Maintenance director or designee with do a monthly walk through for six months to ensure compliance with results brought to QAPI for review. If a threshold of 90% is not	

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	3.1-19(b)		met, an action plan will be developed to ensure compliance. Executive director to monitor for compliance. What date will systemic changes be completed? 8/8/24	