PRINTED: 07/10/2024

	T OF HEALTH AND HUI R MEDICARE & MEDIC			OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155230			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 06/20/2024	
NAME OF	PROVIDER OR SUPPLIER	8		ET ADDRESS, CITY, STATE, ZIP COD O CHESTER BLVD	,	
ROSEBU	JD VILLAGE			HMOND, IN 47374		
(X4) ID PREFIX TAG E 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION DATE
Bldg	conducted by the Ir accordance with 42  Survey Date: 06/20  Facility Number: 0  Provider Number: 100  At this Emergency Village was found in Preparedness Required Medicaid Participat CFR 483.73.  The facility has 110 the survey, the censure of the survey in the survey	000135 155230 266820 Preparedness survey, Rosebud in compliance with Emergency irements for Medicare and dring Providers and Suppliers, 42	E 0000	Dear Brenda Buroker, Attached is Rosebud V plan of correction for Life Code with Emergency Preparedness Survey color on 6/20/2024. Rosebud V requesting paper complia all deficiencies written in Please accept the plan of correction as written. Thank you, Kari Alcorn, HFA Executive Director	Safety mpleted /illage is ance for the 2567.	
K 0000						
Bldg. 01	Licensure Survey w	000135 155230	K 0000	Dear Brenda Buroker, Attached is Rosebud V plan of correction for Life Code with Emergency Preparedness Survey colon 6/20/2024. Rosebud V requesting paper complia all deficiencies written in Please accept the plan of correction as written.	Safety mpleted /illage is ance for the 2567.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

At this Life Safety Code survey, Rosebud Village

was found not in compliance with Requirements

(X6) DATE

Thank you,

Kari Alcorn, HFA

**Executive Director** 

TITLE

Kari Alcorn **Executive Director** 07/08/2024

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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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155230	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(x3) date survey COMPLETED 06/20/2024
	ROVIDER OR SUPPLIER		2050 C	ADDRESS, CITY, STATE, ZIP COD HESTER BLVD OND, IN 47374	
NOOLDO	D VILLAGE		TAIGHIM	OND, IN 47374	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	Subpart 483.90(a), I 2000 edition of the I Association (NFPA) Chapter 19, Existing 410 IAC 16.2.  This one-story facilitype V (111) construction The facility has a find etection in the correcorridors and batteriall resident sleeping capacity of 110 and of this visit.  All areas where resimere sprinkled and a services were sprinkled.	-			
K 0281 SS=F Bldg. 01	discharge, is arran and shall be either or capable of auto manual intervention 18.2.8, 19.2.8  Based on interview determined that the exterior emergency Section 7.9.1.1 required facilities for means the exit access and exit access and exit access and exit access and exit access.	ans of Egress ans of egress, including exit aged in accordance with 7.8 continuously in operation matic operation without	K 0281	/b> /p> /b> All residents with access to cottage courtyard gate have th potential to be affected by the	08/08/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155230		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 06/20/2024	
	PROVIDER OR SUPPLIER JD VILLAGE		2050 C	ADDRESS, CITY, STATE, ZIP COD CHESTER BLVD IOND, IN 47374	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OR including staff, visit were required to every state of the facility of the facility of Maintenance Direct 12:10 p.m. and 2:15 leading to the public leads to a gate with around the aforement illuminated so that sand exit after dark, would illuminate the the coded gate. This finding was ac Director and Maintenance Director and Maintenance of the coded gate.	estatement of Deficiencie CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION For and residents if the facility acuate in an emergency.  The end of the Executive Director and for (MD) on 06/20/24 between for p.m., the exit discharge path for way out of the courtyard for a code to exit. The area futioned gate was not from end of the end of the end of the end of exit discharge around  Romeone could read the code No lights were visible which for each of exit discharge around  Romeone Director at the time of for at the exit conference with	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)  alleged deficiency. Lighting we added near the cottage court gate. (See attachment) The maintenance director or design will conduct rounds to ensure lighting is functioning correctly Any issues will be immediate rectified.  /b>  Maintenance director or design will do an audit of the facility is ensure that all exits are illuminated. Any issues will be immediately rectified.  Maintenance director or design with do a monthly walk througensure compliance. Executive	DATE  //as yard  gnee the y. ly  gnee to e gnee gnee gh to e
K 0293	present. 3.1-19(b)	tor and Maintenance Director		director to monitor for compliance director or design with do a monthly walk through six months to ensure compliance with results brought to QAP1 review. If a threshold of 90% met, an action plan will be developed to ensure compliance executive director to monitor compliance.  What date will systemic changes be completed? 8/8.	gnee gh for ince for is not nce. for
K 0293 SS=E	NFPA 101 Exit Signage				

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<u> </u>		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED			LETED	
		155230	B. WI	NG	_	06/20	/2024
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2050 CHESTER BLVD RICHMOND, IN 47374			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	NIE.	DATE
Bldg. 01	Exit Signage 2012 EXISTING Exit and directional accordance with 7 illumination also so lighting system. 19.2.10.1 (Indicate N/A in or occupancies with where the line of e Based on observation failed to install direct sexits in accordance exits, other than ma obviously and clear shall be marked by readily visible from LSC 7.10.1.2.2 state egress path within a marked by approve where the continuat obvious. This defici and 18 residents on  Findings include:  Based on observation tour of the facility w Maintenance Direct 12:10 p.m. and 2:15 of the end of the "C two paths occupants discharge (right and into the building be other direction led t was confusing which path was not obvious directional signage	al signs are displayed in 7.10 with continuous erved by the emergency ne-story existing less than 30 occupants exit travel is obvious.) on and interview; the facility ectional exit signage in 1 of over se with LSC 7.10. LSC 7.10.1.2.1 in exterior exit doors that ly are identifiable as exits, an approved sign that is any direction of exit access. es horizontal components of the un exit enclosure shall be dexit or directional exit signs ion of the egress path is not tent practice could affect staff	K 02		What corrective action will be accomplished for those reside found to have been affected by deficient practice?  The facility will clearly mark the exit path leading out of the enditor o	e d of rects  e s to llway by A kit of ne nee the ll be	08/08/2024

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155230	B. W	ING		06/20/	2024
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> —</u>	
NAME OF I	PROVIDER OR SUPPLIE	R			HESTER BLVD		
ROSERI	JD VILLAGE				OND, IN 47374		
TOOLDO	- VILLAGE			TAIOTIIVI			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					place and what systemic char	ıges	
	_	cknowledged by the Executive			will be made to ensure the		
	Director and Maintenance Director at the time of				deficient practice does not rec	cur?	
	discovery and again	n at the exit conference with					
	the Executive Director and Maintenance Director				Maintenance director or desig	nee	
	present.				will do an audit of the facility e	xit	
					paths to ensure that all exits a	ıre	
	3.1-19(b)				clearly marked with direction of	of	
					exit path away from building.	Any	
					issues will be immediately		
					rectified. Maintenance directo	r or	
					designee with do a monthly w	alk	
					through to ensure compliance	÷ <b>.</b>	
					Executive director to monitor t	for	
					compliance.		
					How the corrective action will	be	
					monitored to ensure the defici	ent	
					practice will not recur and wha	at	
					quality assurance program wil		
					put into place?		
					Maintenance director or desig	nee	
					with do a monthly walk throug	h for	
					six months to ensure complian	nce	
					with results brought to QAPI for	or	
					review. If a threshold of 90% i	s not	
					met, an action plan will be		
					developed to ensure compliar	ice.	
					Executive director to monitor t	for	
					compliance.		
					What date will systemic chang	100	
					be completed? 8/8/24	) <del>c</del> o	
					be completed! 0/0/24		
K 0363	NFPA 101						
SS=E	Corridor - Doors						
Bldg. 01	Corridor - Doors					ļ	
-		corridor openings in other					

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	ND PLAN OF CORRECTION IDENTIFICATION NUMBER  155230   A. BUILDING 01  B. WING		COMPLETED 06/20/2024		
NAME OF I	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD CHESTER BLVD	
ROSEBL	JD VILLAGE			MOND, IN 47374	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
1710		losures of vertical openings,	1710		DATE
	· ·	s areas resist the passage			
		made of 1 3/4 inch			
	solid-bonded core	wood or other material			
	capable of resistir	ng fire for at least 20			
	minutes. Doors in	fully sprinklered smoke			
	compartments are	only required to resist the			
	passage of smoke	e. Corridor doors and doors			
	to rooms containir	_			
		rials have positive latching			
		atches are prohibited by			
	_	hese requirements do not			
	apply to auxiliary s	spaces that do not contain			
		en bottom of door and floor			
		ceeding 1 inch. Powered			
	_	vith 7.2.1.9 are permissible			
		device capable of keeping			
	I	hen a force of 5 lbf is			
		no impediment to the			
		rs. Hold open devices that			
	release when the	door is pushed or pulled are			
	permitted. Nonrate	ed protective plates of			
	_	re permitted. Dutch doors			
		6 are permitted. Door			
		beled and made of steel or			
		compliance with 8.3,			
	unless the smoke				
		fire window assemblies are n sprinklered compartments			
	· ·	ctions in area or fire			
		s or frames in window			
	assemblies.	o or mannes in window			
	483, and 485 Show in REMARK	Parts 403, 418, 460, 482,  (S details of doors such as ngs, automatics closing			
	devices, etc.	g., Laternation blooming			
		on and interview, the facility	K 0363	What corrective action will be	08/08/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUI	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED				
		155230	B. WIN	[G		06/20/	2024
		<u>!</u>	<del>'                                    </del>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8			HESTER BLVD		
ROSEBU	JD VILLAGE		RICHMOND, IN 47374				
(VA) ID	CIDANADA	CTATEMENT OF DEFICIENCIE	<del></del> L	ID			(V5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	,		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5)
TAG	·	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		REFIX TAG	CROSS-REFERENCED TO THE APPROPRIA'  DEFICIENCY)	TE	COMPLETION DATE
IAU		corridor doors had no		IAU	accomplished for those reside	nte	DATE
	impediment to closing and latching into the door				found to have been affected b		
	_	sist the passage of smoke.			deficient practice?	y ti ie	
		ice could affect 6 staff and 15			denoient practice:		
	residents.				The facility removed the door		
					obstructions for rooms 40, 32,	and	
	Findings include:				therapy area.		
					The facility adjusted the doors	for	
	Based on observation	ons and interview during a			rooms 50 and 49, the business		
		with the Executive Director and			office, and activity area to prev		
	Maintenance Direct	tor on 06/20/24 between 12:10			dragging.		
	p.m. and 2:15 p.m.,	the following corridor doors			The facility will repair the		
	failed to latch positi	ively into their respective door			self-closing latch on the cottag	je	
	frames or have no in	mpediment to closing:			housekeeping mechanical roo	m	
					door and activity area door.		
	a) Resident Roon	n #50, the door was dragging			The facility will remove the		
	on the floor.				self-closing latch on the busine	ess	
	· ·	n #49, the door was dragging			office as it is no longer warran	ted.	
	on the floor.						
		a Door, with delf-closing			How other residents having the		
	device, failed to sel				potential to be affected by the		
		Office door, with delf-closing			same deficient practice will be		
	device, failed to sel				identified and what corrective		
	1 '	mechanical room on the			action will be taken?		
		elf-closing device, failed to					
	self-close and latch.				All residents with access to ro		
	\ D '1 (D	n #40 door obstruction.			32, 40, 49, 50, the business of		
	_ ·	n #32 door obstruction.			the activity area, and the cotta	-	
	h) Therapy area c	corridor door, obstruction.			housekeeping mechanical roo		
	This finding was as	knowledged by the Evecutive			have the ability to be affected	-	
		knowledged by the Executive enance Director at the time of			the alleged deficient practice.		
		at the exit conference with			maintenance director or design will conduct rounds to ensure		
		etor and Maintenance Director			all doors close and latch corre		
	present.	not and manifemente Director			and that doors do not drag the	-	
	Present				floor, and there are no door	,	
	3.1-19(b)				obstructions. Any issues will b	e	
					immediately rectified.	-	
					miniodiatory rootiliod.		
					What measures will be put into	n	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR	R MEDICARE & MEDIC				OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155230	(X2) MULTIPLE A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 06/20/2024
	PROVIDER OR SUPPLIEI JD VILLAGE	3	2050	T ADDRESS, CITY, STATE, ZIP COD CHESTER BLVD MOND, IN 47374	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE
				place and what systemic char will be made to ensure the deficient practice does not re-	
				The maintenance director or designee will conduct rounds ensure that all doors close an latch correctly and that doors not drag the floor, and there a door obstructions. Any issues be immediately rectified. Any issues will be immediately rectified. Maintenance directed designee with do a monthly withrough to ensure compliance.  How the corrective action will monitored to ensure the deficient practice will not recur and which quality assurance program with put into place?  Maintenance director or design with do a monthly walk through six months to ensure compliance with results brought to QAPI for review. If a threshold of 90% met, an action plan will be developed to ensure compliant Executive director to monitor compliance.	and do
				What date will systemic change be completed? 8/8/24	ges

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	1	ILDING	01	COMPLETED	
		155230	B. WI	NG		06/20/	/2024
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2050 CHESTER BLVD RICHMOND, IN 47374			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0372	NFPA 101						
SS=E	Subdivision of Bui	lding Spaces - Smoke					
Bldg. 01	Barrie						
		lding Spaces - Smoke					
	Barrier Construction	on					
	2012 EXISTING						
		nall be constructed to a					
		tance rating per 8.5. Smoke					
	·	ermitted to terminate at an					
		e 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 barri						
	19.3.7.3, 8.6.7.1(1	•					
	Describe any med system in REMAR	hanical smoke control RKS.					
		on and interview, the facility	K 03	372	What corrective action will be		08/08/2024
	failed to ensure the	smoke barrier ceiling in the			accomplished for those reside	nts	
	mechanical room w	as protected to maintain the			found to have been affected by the		
	smoke resistance of	each smoke barrier. LSC			deficient practice?		
	Section 19.3.7.5 rec	uires smoke barriers to be					
	constructed in accor	rdance with LSC Section 8.5			The facility sealed the attic		
	and shall have a min	nimum ½ hour fire resistive			access in the mechanical roor	n.	
	rating. LSC Section	8.5.2.1 requires smoke barriers			The facility covered the access	S	
		om an outside wall to an			panel with material that is		
		floor to a floor, or from a			adequate and with fire resistar	nce	
	smoke barrier to a s	moke barrier, or by use of a			rating.		
		f. 8.5.6.2 requires penetrations					
		ys, conduits, pipes, tubes,			How other residents having th	е	
		nilar items to accommodate			potential to be affected by the		
	electrical, mechanic	-			same deficient practice will be		
		stems that pass through a wall,			identified and what corrective		
	· ·	g assembly constructed as a			action will be taken?		
		rough the ceiling membrane of					
	_	smoke barrier assembly, shall			All residents within the same		
		stem or material capable of			smoke barrier area of the		
	_	ement of smoke. This deficient			mechanical room have the abi	lity	
	practice could affec	t 3 staff.			to be affected by the alleged		
			1		deficient practice. The		I

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155230	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  01	COMP	E SURVEY PLETED 0/2024
	PROVIDER OR SUPPLIEF		2050 0	ADDRESS, CITY, STATE, ZIP COI CHESTER BLVD MOND, IN 47374	)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ETION JLD BE ROPRIATE	(X5) COMPLETION DATE
	Based on observation tour of the facility of Maintenance Direct 12:10 p.m. and 2:15 in the mechanical resort the survey. Furth cover the access did the entire area of the the fire resistance resort This finding was accommodified Director and Mainten discovery and again	ons and interview during a with the Executive Director and for (MD) on 06/20/24 between 5 p.m., the attic access location from was unsealed at the time termore, the material used to dinot appear adequate to cover the ceiling penetration not have		maintenance director or will conduct rounds to en attic access is sealed an with adequate, fire resist rating material. Any issue immediately rectified.  What measures will be pplace and what systemic will be made to ensure the deficient practice does not rectified. The maintenance director designee will conduct routensure that attic access and covered with adequatesistance rating material issues will be immediated rectified. Any issues will immediately rectified. Maintenance director or with do a monthly walk the ensure compliance. Executive director or with do a monthly walk the six months to ensure the practice will not recur and quality assurance prograput into place?  Maintenance director or with do a monthly walk the six months to ensure cor with results brought to Que review. If a threshold of 9 met, an action plan will be developed to ensure con Executive director to moncompliance.	designee sure that d covered ance es will be ut into changes ne ot recur?  or or unds to is sealed ate, fire I. Any be designee arough to cutive impliance.  In will be deficient d what im will be designee arough for impliance API for 20% is not e inpliance.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES	

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155230		JILDING	onstruction 01		E SURVEY PLETED 0/2024	
	ROVIDER OR SUPPLIER D VILLAGE			2050 CI	ADDRESS, CITY, STATE, ZIP COD HESTER BLVD OND, IN 47374			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
K 0711 SS=F Bldg. 01	patients and for the of an emergency. Employees are per kept informed with and a copy of the with telephone open plan addresses the of staff per 18/19.7 of the fire safety per 18/19.2.2.  18.7.1.1 through 19.7.2.1 through 19.7.2.1.2, 19.7.2.1 through 19.7.2.1.2, 19.7.2.1 Based on record revinterview; the facility plan that addressed written fire plans. It health care occupant provide for the follow (1) Use of alarms (2) Transmission of (3) Emergency phore (4) Response to alar (5) Isolation of fire (6) Evacuation of structure of the follow (1) Evacuation of structure of the follow (2) Isolation of fire (3) Evacuation of structure of the follow (3) Evacuation of structure of the follow (4) Response to alar (5) Isolation of fire (6) Evacuation of structure of the follow (5) Isolation of structure of the follow (6) Evacuation of structure of the follow (7) Evacuation of structure of the follow (6) Evacuation of structure of the follow (7) Evacu	elocation Plan plan for the protection of all eir evacuation in the event riodically instructed and their duties under the plan, plan is readily available erator or with security. The e basic response required 7.2.1.2 and provides for all lan components per 8.7.1.3, 18.7.2.1.2, 19.7.1.1 through 19.7.1.3, 2, 19.7.2.3 iew, observation and ty failed to provide a written all components in 1 of 1 LSC 19.7.2.2 requires a written cy fire safety plan that shall lawing: alarm to fire department the call to fire department ms mmediate area	K 0	711	What corrective action will be accomplished for those reside found to have been affected by 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?	nts y the	08/08/2024	
	(9) Extinguishment Section 19.2.3.4(4)	of fire Projections into the required			All residents within the facility have the ability to be affected	by		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		NSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDIN	NG	01	COMPLETED			
		155230	B. WING			06/20/			
			STR	REET A	DDRESS, CITY, STATE, ZIP COD				
NAME OF F	PROVIDER OR SUPPLIER	8			HESTER BLVD				
ROSEBUD VILLAGE				RICHMOND, IN 47374					
<u></u>				ı			(VE)		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE  (FACH DEFICIENCY MUST BE DESCEDED BY FULL)		ID	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION		
TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL  PEGULATORY OF LSC IDENTIFYING INFORMATION		PREFI TAC		CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION width shall be permitted for wheeled equipment,		IAC		the alleged deficient practice.	The	DATE		
	provided that all of the following conditions are				maintenance director or design				
	met:			will conduct rounds to ensure t					
	(a) The wheeled equipment does not reduce the			facility maps are present		ınaı			
	clear unobstructed corridor width to less than 60			identifying smoke					
	inches.			compartments/firewalls.					
	(b) The health care occupancy fire safety plan and				issues will be immediately				
	training program address the relocation of the				rectified.				
	wheeled equipment during a fire or similar								
	emergency.				What measures will be put into	o			
	(c)The wheeled equipment is limited to the				place and what systemic chan				
	following:				will be made to ensure the	J			
	i. Equipment in use and carts in use				deficient practice does not rec	ur?			
	ii. Medical emerger	ncy equipment not in use			·				
	iii. Patient lift and transport equipment				The maintenance director or				
	This deficient practice could affect all occupants.				designee will conduct rounds t	to			
					ensure that facility maps are				
	Findings include:				present identifying smoke				
					compartments/firewalls. Any				
	Based on observations and interview during a				issues will be immediately				
	tour of the facility and records review with the				rectified. Any issues will be				
	Executive Director and Maintenance Director				immediately rectified.				
	(MD) on 06/20/24 between 12:10 p.m. and 2:15				Maintenance director or design				
	p.m., the written fire safety plan did not identify			with do a monthly walk throug					
	the facility's smoke compartments or firewalls.				ensure compliance. Executive				
	Based on interview at the time of review, the MD			director to monitor for co					
	acknowledged the aforementioned written fire			All staff will be educat					
	safety plan did not address the location of the				smoke compartments/firewalls	S			
	-	npartments. The map provided							
	only identified the location of the facility's fire				How the corrective action will I				
	extinguishers. The MD stated that they did not				monitored to ensure the deficie				
	have a diagram showing the smoke compartments			practice will not recur and what					
	or firewalls.				quality assurance program wil	ı be			
	This finding was as	knowledged by the Evecutive			put into place?				
	This finding was acknowledged by the Executive Director and Maintenance Director at the time of				Maintanance director or design	200			
discovery and again at the exit conference with			Maintenance director or design						
		etor and Maintenance Director			with do a monthly walk through				
		nor and mannenance Director			six months to ensure compliar with results brought to QAPI for				
	present.				review If a threshold of 90% is				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155230	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 06/20/2024		
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP COD 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 APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	3.1-19(b)				met, an action plan will be developed to ensure compliant Executive director to monitor for compliance.  What date will systemic chang be completed? 8/8/24	or		

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