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	04/23/2018

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 State Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/23/18 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 91. Quality Review completed on 04/27/18 - DA	E 0000	K000 The Plan of Correction Constitutes the centers allegation of compliance. The following plan of correction is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparation an execution of this response and the plan of correction does not constitute an admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State Law.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/23/18 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	K000 The Plan of Correction Constitutes the centers allegation of compliance. The following plan of correction is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparation an execution of this response and the plan of correction does not constitute an admission or agreement by the provider of the truth or the facts	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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 (000) 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 91 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 04/27/18 - DA		alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State Law.	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 2 of 8 exit discharges was constructed to prevent elevation changes in accordance with LSC 7.1.7. LSC 7.1.6.2 requires abrupt changes in elevation of walking surfaces	K 0271	K271 What corrective action will take place for those residents found to be affected by the deficient	05/23/2018

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	shall not exceed 1/4 in. (6.3 mm). Changes in elevation exceeding 1/4 in. (6.3 mm), but not exceeding 1/2 in. (13 mm), shell be beveled with a slope of 1 in 2. Changes in elevation exceeding 1/2 in. (13 mm) shall be considered a change in level and shall be subject to the requirements of 7.1.7. This deficient practice could affect 22 residents who reside on A Hall and 57 residents who use the main dining room. Findings include: Based on observations with the maintenance supervisor on 04/23/18 during an initial tour of the facility from 9:35 a.m. to 10:00 a.m., the A Hall exit sidewalk surface had a one inch to two inch elevation differences on three, four foot by three foot concrete slabs located in the middle and the end at the parking lot locations along the one hundred forty foot long sidewalk surface and the three concrete slabs were broken and crumbling. Furthermore, the main dining room exit sidewalk surface had two, three foot three foot concrete slabs located in the middle and the end at the parking lot locations along the one hundred forty foot long sidewalk surface and the three concrete slabs were broken and crumbling. Furthermore, the main dining room exit had a one inch elevation difference on the three, three foot by three foot sections of concrete slabs in the center of the sixty foot long sidewalk surface and the three concrete slabs were broken and crumbling. This was measured and confirmed by the maintenance supervisor at the time of observations. 3.1-19(b)		practice? No residents were affected; however, for those 91 residents having the potential to be affected all areas will be corrected as soon as possible. Quotes for repair are being obtained and repairs will take place once vendor is available to begin, no later than June 30, 2018. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents had the potential to be affected; alleged deficient practice will be corrected; quotes for repair are being obtained and repairs will take place once vendor is available to begin, no later than June 30, 2018. . What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; a CQI monitoring tool will be completed by the Maintenance Director Monthly x's 3, Quarterly x's 1 to total at least 6 months. Audit tools will be submitted to the CQI committee and action plans will be developed as needed if the threshold of 95% is not met. How the corrective action(s) will be monitored to ensure the deficient	

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			practice will not recur, i.e., what quality assurance program will be put into place; a CQI monitoring tool will be completed by the Maintenance Director Monthly x's 3, Quarterly x's 1 to total at least 6 months. Audit tools will be submitted to the CQI committee and action plans will be developed as needed if the threshold of 95% is not met. By what date the systemic changes will be completed; May 23, 2018.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to ensure fire drills were held on 2 of 3 shifts for 3 of 4 quarters over the past year and 4 of 12 fire drills over the past year included transmission of the fire alarm signal. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation	K 0712	K712 What corrective action will take place for those residents found to be affected by the deficient practice? No residents were affected; however, for those 91 residents having the potential to	05/23/2018

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	of emergency fire conditions. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of Monthly Fire Drill Reports with the maintenance supervisor on 04/23/18 at 10:40 a.m., there was fire drills held on 04/18/18 at 7:15 p.m., 03/20/18 at 5:25 a.m., 12/25/17 at 2:00 a.m., and 07/29/17 at 2:37 a.m. and each lacked documentation of the transmission of the fire alarm signal on the Monthly Fire Drill Reports. Based on an interview with the maintenance supervisor at the time of record review, it was stated the fire alarm system is not tested on third shift fire drills and the 04/18/18 7:15 p.m. fire drill also lacked a test of the fire alarm system. 3.1-19(b)		be affected alleged deficient practice will be corrected on or before May 23, 2018. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents had the potential to be affected; the Maintenance Director will conduct staggered fire drills as per regulation monthly, maintenance director will call monitoring company after drills are conducted to ensure that monitoring company received fire alarm pull and document call to monitoring company. The ED/DNS will sign off on documented to ensure call has been made to monitoring company did receive call and signal. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; a CQI monitoring tool will be completed by the Maintenance Director Monthly x's 3, Quarterly x's 1 to total at least 6 months. Audit tools will be submitted to the CQI committee and action plans will be developed as needed if the threshold of 95% is not met. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; a CQI monitoring tool will be completed by the	

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			Maintenance Director Monthly x's 3, Quarterly x's 1 to total at least 6 months. Audit tools will be submitted to the CQI committee and action plans will be developed as needed if the threshold of 95% is not met. By what date the systemic changes will be completed; May 23, 2018.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied			

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	shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on record review, observation and interview, the facility failed to ensure a metal container with self-closing cover devices into which ashtrays can be emptied were used at 2 of 4 outdoor areas where smoking is permitted. This deficient practice could affect any number of residents and staff who use the outside smoking locations. Findings include: Based on review of the facility's written smoking policy on 04/23/18 at 10:50 a.m. with the maintenance supervisor, resident and staff smoking is permitted on the premises at four outside smoking locations. Based on observation with the maintenance supervisor on 04/23/18 during a tour of the outside smoking locations from 12:10 p.m. to 1:00 p.m., the front entrance smoking location had approximately one hundred unlit cigarette butts on the ground surface on the sidewalk and in the wooden mulch and lacked a metal container with a self closing cover for the ashtray to be emptied into and the picnic table smoking location had approximately two hundred unlit cigarette butts on the ground surface and lacked a metal container with self closing cover for the ashtrays to be emptied into and an ashtray. This was confirmed by the maintenance supervisor at the time of observations. 3.1-19(b)	K 0741	K741 What corrective action will take place for those residents found to be affected by the deficient practice? No residents were affected; however, for those 91 residents having the potential to be affected alleged deficient practice will be corrected on or before May 23, 2018. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents had the potential to be affected; the Maintenance Director identified one smoking area on the premises and will ensure that metal containers with self-closing cover devices into which ashtrays can be emptied are at designated smoking area. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The Maintenance Director will the Maintenance Director will conduct an in-service with all staff regarding the company's smoking policy and will be completed by May 23, 2018; as well as educate staff on where designated smoking area is located. Any staff found to violate smoking in designated smoking area may be disciplined	05/23/2018

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			up to the point of termination. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; a CQI monitoring tool will be completed by the Maintenance Director Monthly x's 3, Quarterly x's 1 to total at least 6 months. Audit tools will be submitted to the CQI committee and action plans will be developed as needed if the threshold of 95% is not met. By what date the systemic changes will be completed; May 23, 2018.	