STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 01 B. WING	04/10/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
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 483.70(a). Survey Date: 04/10/17 Facility Number: 000135 Provider Number: 155230 AIM Number: 100266820 At this Life Safety Code survey, Rosebud Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(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 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 96 at the time of this visit.	K 0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	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 04/18/17 - DA			
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 5 of 10 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers	K 0374	K 0374 What corrective action will take place for those residents found to be affected by the deficient practice? No residents were affected; how ever for those 97 having the potential to be affected all areas have been corrected. The service hall set of smoke barrier doors by	05/08/2017

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	to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice affects 20 residents who reside on the Main Street. Findings include: Based on observations on 04/10/17 during a tour of the facility from 9:50 a.m. to 1:13 p.m. with the maintenance supervisor, the following sets of smoke barrier doors failed to resist the passage of smoke; a. The Maintenance Hall set of smoke barrier doors had a one inch gap along the center where the doors came together in the closed position and each door had two, one half inch diameter holes near the top of each door. b. The C Hall set of smoke barrier doors had a one inch gap along the center where the doors came together in the closed position and each door had two, one half inch diameter holes near the top of each door. c. The D Hall set of smoke barrier doors had two, one half inch diameter holes near the top of each door. d. The B Hall set of smoke barrier doors had a one inch gap along the center where the doors came together in the closed position.		the maintenance office, the fire barrier doors on the therapy hall, and A-hall fire barrier doors all had closure adjustments made to them to ensure proper closure of the doors. Aluminum flat strips were added to the Cottage fire barrier doors to ensure that there are no gaps. Fire rated caulk (Flamesafe FS 900+ Elastomeric Firestop product code 66831) was added to holes on D-Hall doors, C-Hall fire barrier doors, and service hall fire barrier doors next to the maintenance director's office. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? Allresidents had the potential to be affected. Maintenance Director ensured that all areas have been corrected and all other areas inspected to ensure no other deficiencies. The service hall set of smoke barrier doors by the maintenance office, the fire barrier doors on the therapy hall, and A-hall fire barrier doors all had closure adjustments made to them to ensure proper closure of the doors. Aluminum flat strips were added to the Cottage fire barrier doors to ensure that there are no gaps. Fire rated caulk (Flamesafe FS 900+ Elastomeric Firestop product code 66831) was added to holes on D-Hall doors, C-Hall fire barrier doors, and	

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	e. The A Hall set of smoke barrier doors had a one inch gap along the center where the doors came together in the closed position. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 04/10/17 at 1:15 p.m. 3.1-19(b)		service hall fire barrier doors next to the maintenance director's office. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not re-occur?** Maintenance Director will check all barrier doors on a routine basis. A CQI monitoring tool will be completed by Maintenance Director weekly times four weeks and then monthly times 2 months and quarterly times 1 for a total of at least six 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 will the corrective actions be monitored to ensure they do not occur again?** **A CQI monitoring tool will be completed by Maintenance Director weekly times four weeks and then monthly times 2 months and quarterly times 1 to total at least six months. Audit tools will be submitted to the CQI committee and action plans will be developed**	

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			as needed if the threshold of 95% is not met. **Date systemic changes will be completed; May 08, 2017**	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 3 of 66 resident rooms and 2 of 6 common resident use areas did not use power strips for resident electrical equipment. This deficient practice affects 6 residents who reside in	K 0920	K 0920 What corrective action will take place for those residents found to be affected by the deficient practice? No residents were affected; however, for those 97 having the	05/10/2017

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	resident rooms 52, 60 and 61, 14 residents who use the Main Hall lounge, and 8 residents who use the therapy room. Findings include: Based on observations on 04/10/17 during a tour of the facility with the maintenance supervisor from 9:50 a.m. to 1:13 p.m., resident rooms 52, 60, 61, the Main Hall resident lounge and the therapy room each used a power strip for resident's personal electrical equipment items including televisions, alarm clocks, computers, bed side lights, and floor fans. Additionally, the power strips used by the facility lacked a UL 1363 label on each power strip used in the resident rooms, the Main Hall lounge and the therapy room. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 04/10/17 at 1:15 p.m. 3.1-19(b)		potential to be affected all areas have been corrected. Maintenance Director Order Medical Grade Power Strips for patient care areas with 6 outlets and a 15-foot cord to replace the standard power strips that were being utilized. 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 had the potential to be affected. Maintenance Director ensured that all areas have been corrected and all other areas inspected to ensure no other deficiencies. All standard power strips in resident patient care areas are being removed and replaced with medical grade power strips with 6 outlets and a 15-foot cord; to ensure compliance and resident safety. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not re-occur? Maintenance Director will keep himself updated with Life Safety Code changes to ensure that we are staying compliant. A CQI monitoring tool will be completed by Maintenance Director weekly times four weeks and then monthly times	

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			2 months and quarterly times 1 to total of at least six 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 will the corrective actions be monitored to ensure they do not occur again?** **A CQI monitoring tool will be completed by Maintenance Director weekly times four weeks and then monthly times 2 months and quarterly times 1 to total of at least six 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.** Date the systemic changes will be completed: May 10, 2017	