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	05/24/2023

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

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/24/23 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 95. Quality Review completed on 05/30/23	E 0000	Dear Brenda Buroker, Attached is Rosebud Village's plan of correction for Life Safety Code with Emergency Preparedness Survey completed on 5/24/2023. 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: 05/24/23 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 5/24/2023. Rosebud Village is requesting paper compliance for all deficiencies written in the 2567. Please accept the plan of correction as written. Thank you,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kari Alcorn		06/16/2023

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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	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 95 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 05/30/23		Kari Alcorn, HFA Executive Director	
K 0222 SS=E 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			

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	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 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			

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	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 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 1 of over 10 means of egress 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. This deficient practice could affect 4, staff and visitors if needing to exit the facility. Findings include: Based on observations and interview during a tour of the facility with the Executive Director and Maintenance Director on 05/24/23 between 11:45 a.m. and 1:45 p.m. the exit door, marked as a facility exit, in the service hall corridor was magnetically locked and could be opened by entering a four-digit code but the code was not posted. The Maintenance Director stated that the code was once there but had either fallen off or been removed. 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.	K 0222	K 222 Egress Doors What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The facility will post codes to exit doors in an obvious fashion at the exit door located at the employee entrance/exit. 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 exit doors have the potential to be affected by the alleged deficiency. The code is now posted at the exit door in an obvious fashion. (See attachment) The maintenance director or designee will conduct rounds to ensure that codes are posted in an obvious fashion. 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?	06/15/2023

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	3.1-19(b)		Maintenance director or designee will do an audit of the facility to ensure that codes are posted in an obvious fashion. 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? 6/15/23	
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.			

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	18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 1 of over 4 exit discharges had a level walking surface, were free of obstructions, and constructed of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect 12 residents and staff. Findings include: Based on observations and interview during a tour of the facility with the Executive Director and Maintenance Director on 05/24/23 between 11:45 a.m. and 1:45 p.m. the exit discharge sidewalk in the Courtyard had a large crack in the concrete, was uneven and the rise in separation created a trip hazard. The Maintenance Director acknowledged that the walkway was in need of repair to have a complete level walking surface that was free of trip hazards leading to the common way stating that the tree roots cause the sidewalk to rise and that this has been a problem in the past. 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)	K 0271	K 271 Discharge from Exits What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The facility will replace/repair exit discharge sidewalk that is uneven/unlevel in the courtyard by 7/31/23. The facility has secured an outside vendor to complete the sidewalk repairs/replacement. The facility has identified the unlevel surface by brightly colored paint until the replacement/repair is completed. The facility has secured an outside vendor to remove the tree from the area that is causing the sidewalk to become uneven. 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 discharge sidewalk in the courtyard have the ability to be affected by the alleged deficient practice. The maintenance director has inspected all exit discharge sidewalks to ensure that surfaces are level and free from obstructions. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur?	07/31/2023

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			Maintenance director or designee will do an audit of the facility exit discharge sidewalks to ensure that surfaces are level and free from obstructions. 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? 7/31/23	
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			

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	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 1 of 1 flexible cords power strips powering medical equipment was not also powering non-medical equipment. This deficient practice affects 2 residents. Findings include: Based on observations and interview during a tour of the facility with the Executive Director and Maintenance Director on 05/24/23 between 11:45 a.m. and 1:45 p.m. a hospital bed mattress was plugged in to a power strip along with non-medical personal electronic equipment. 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.	K 0920	K 920 Electrical Equipment What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The facility separated medical equipment and non-medical equipment into separate approved power strips(UL1363 & UL1363A)/outlets. The facility purchased additional approved power strips(UL1363 & UL1363A) so that medical and non-medical equipment can be separated. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?	06/30/2023

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	3.1-19(b)		All residents who utilize medical and non-medical equipment and power strips have the potential to be effected by this alleged deficient practice. The maintenance director or designee will conduct rounds to ensure that medical equipment and non-medical equipment are not plugged into the same power strip. 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 medical equipment and non-medical equipment are not plugged into the same power strip. 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	

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			met, an action plan will be developed to ensure compliance. Executive director to monitor for compliance. What date will systemic changes be completed? 6/30/23	