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	02/24/2022

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: 02/24/22 Facility Number: 000135 Provider Number: 155230 AIM Number: 100266820 At this Emergency Preparedness survey, Rosebud Village was found in substantial 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 83. Quality Review completed on 02/28/22	E 0000	Dear Brenda Buroker, Attached is Rosebud Village's plan of correction for Life Safety Code with Emergency Preparedness Survey completed on 2/24/2022. Rosebud Village is requesting paper compliance for all deficiencies written in the 2567. We are requesting Temporary Waivers for K353, K351, K511 and K222. Please accept the plan of correction as written. Thank you, Kari Alcorn, HFA Executive Director Rosebud Village	
E 0039 SS=C Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:			

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

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	(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):]			

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	(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or			

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	(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual,			

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	facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires			

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	activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the			

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	LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the			

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	onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or			

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	functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as			

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	needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise.	E 0039	E039 EP Testing Requirements What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The facility will conduct a second exercise of choice, severe weather, to test the emergency preparedness plan. The facility will complete emergency preparedness drills per regulations. 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	03/21/2022

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	b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review and interview with the Maintenance Director and Executive Director on 02/24/22 between 11:00 a.m. and 1:00 p.m., the facility was able to provide documentation of its response to the COVID-19 Public Health Emergency, however, was unable to provide documentation of a second exercise of choice to test the emergency preparedness plan. Based on interview at the time of record review, the Executive Director agreed that a second exercise of choice was not conducted. This deficient finding was reviewed with the Maintenance Director and Executive Director at the time of discovery and again at the exit conference at 3:45 p.m.		the alleged deficient practice. The facility conducted a second exercise of choice, severe weather, to test the emergency preparedness plan. (See attachment: Tabletop Exercise) The facility will conduct emergency preparedness exercises per regulations, the facility will utilize TELS system for scheduling of exercises. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? Executive director or designee will schedule emergency preparedness exercises utilizing the TELS system. Exercises will be completed within the month that they are scheduled. Any issues will be immediately rectified. Executive Director will 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? Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. Disaster and emergency preparedness QAPI tool will be	

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			completed weekly x 4 weeks, monthly x 6 months, and quarterly there after until compliance is achieved. If Threshold of 90% is not met, an action plan will be developed to ensure compliance. What date will systemic change be completed? 3/21/22	
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: 02/24/22 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 483.90(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	K 0000	Dear Brenda Buroker, Attached is Rosebud Village's plan of correction for Life Safety Code with Emergency Preparedness Survey completed on 2/24/2022. Rosebud Village is requesting paper compliance for all deficiencies written in the 2567. We are requesting Temporary Waivers for K353, K351, K511 and K222. Please accept the plan of correction as written. Thank you, Kari Alcorn, HFA Executive Director Rosebud Village	

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	corridors and battery-operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 110 and had a census of 83 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 02/28/22			
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 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			

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	155230	A. BUILDING 01 B. WING	02/24/2022

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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
	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 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			
	1. Based on observation and interview, the facility failed to ensure the means of egress through all	K 0222	=”” b=””> **b=””>**	06/21/2022

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	exits was 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 over 15, staff and visitors if needing to exit the facility. Findings include: Based on observations during a tour of the facility with the Executive Director and Maintenance Director on 02/24/22 between 1:00 p.m. and 3:30 p.m., the following exits either did not have the code posted or it was posted in a fashion which was not obvious to the public: (A) The two south exit doors in the main dining room were posted in a fashion that was not obvious to the public. (B) The exit door on the "C" hall near room 39 was posted in a fashion that was not obvious to the public. (C) The exit door near the vending machines was posted in a fashion that was not obvious to the public. (D) The exit gate from the Cottage Courtyard was not posted at all. The aforementioned doors and gate were magnetically locked and could be opened by entering a four-digit code but the code was not posted at the exit or posted in a manner not obvious to the public. This deficient finding was reviewed with the Maintenance Director and Executive Director at the time of discovery and again at the exit		=”” b=””> =”” p=””> =”” p=””> =”” b=””> **b=””>** =”” b=””> =”” p=””> =”” p=””> K222 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 two south exit doors in the main dining room, the exit door on “C” hall near room 39, the exit door near the vending machines, and the exit gate from the cottage courtyard. The facility will replace the exit door in the kitchen by 6/21/22. The facility is requesting a temporary waiver for exit door replacement, see attached temporary waiver request and letter of intent from contracted company who will complete the work. 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 each	

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	conference at 3:45 p.m. 2. Based on observation and interview, the facility failed to ensure all exterior exit doors were readily accessible and able to open on first try. This deficient practice could affect 6 occupants in the kitchen area. Findings include: Based on observations during a tour of the facility with the Executive Director and Maintenance Director on 02/24/22 between 1:00 p.m. and 3:30 p.m., the exit door in the kitchen to the outside would not open when tested. The Surveyor, Maintenance Director and Kitchen Staff tried to open the door, but the door was wedged and would not open. The Maintenance Director stated the door was not properly working and will need to be replaced. This deficient finding was reviewed with the Maintenance Director and Executive Director at the time of discovery and again at the exit conference at 3:45 p.m. 3.1-19(b)		exit door in an obvious fashion. (See attachment) The facility will replace the exit door in the kitchen by 6/21/22. The maintenance director or designee will conduct rounds to ensure that codes are posted in an obvious fashion. The maintenance director or designee will conduct rounds to ensure that the kitchen door opens appropriately. 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? Maintenance director or designee will do an audit of the facility to ensure that codes are posted in an obvious fashion. The maintenance director or designee will ensure that the kitchen exit door opens appropriately. 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	

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			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? 6/21/22 ="" b="">	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) 1. Based on observation and interview, the facility failed to ensure that a complete automatic sprinkler system or documentation of fire retardant material was provided for 1 of 1 canvas	K 0351	="" b=""> **b="">** ="" b=""> ="" p="">	06/21/2022

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	canopies. NFPA 13-2010 Edition, Section 8.15.7.1 states sprinklers shall be installed under exterior roofs, canopies, porte-cocheres, balconies, decks, or similar projections exceeding 4 ft. (1.2 m) in width. Section 8.15.7.2 states sprinklers shall be permitted to be omitted where the canopies, roofs, porte-cocheres, balconies, decks, or similar projections are constructed with materials that are noncombustible or limited-combustible, or fire retardant. Textiles such as canvas used as an awning shall meet NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. This deficient practice could affect at least 30 residents evacuating the facility. Findings include: Based on observations during a tour of the facility with the Executive Director and Maintenance Director on 02/24/22 between 1:00 p.m. and 3:30 p.m., there was a canvas canopy on the "D" hall exit near room 57 which measured approximately 15X12 feet, not sprinkled and attached to the building. Based on record review with the Maintenance Director no documentation could be provided to show the canvas was inherently flame retardant. Based on interview at the time of records review the Maintenance Director acknowledged there was no sprinkler coverage for the canopy and confirmed there was no documentation to show the canvas canopy was inherently fire retardant. This deficient finding was reviewed with the Maintenance Director and Executive Director at the time of discovery and again at the exit conference at 3:45 p.m. 2. Based on observation and interview, the facility failed to maintain the ceiling construction in in accordance with NFPA 13, Standard for the		=”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” b=””> K351 Sprinkler System What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The facility will install complete automatic sprinkler system to canvas canopy located outside of “D” hall exit near room 57 by 6/21/22. The facility will repair/replace sprinkler head escutcheons and ensure that they cover the hole around the sprinklers in the following areas: the corridor by the business office and main entrance, the corridor outside of room 41 and in the staff development coordinators office. The facility will move the sprinkler head located in the dryer room so that it is not within one inch of the side wall. The facility is requesting a temporary waiver for the sprinkler system work and repairs, see attached for the temporary waiver request and letter of intent from the contracted company to complete the work. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?	

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	Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff and up to 6 staff. Findings include: Based on observations during a tour of the facility with the Executive Director and Maintenance Director on 02/24/22 between 1:00 p.m. and 3:30 p.m., (A) in the corridor near the Business Office and Main Entrance and (B) in the corridor outside room 41, and (C) in the Staff Development Coordinators office, Sprinkler Heads were missing an escutcheon and did not completely cover the hole around the sprinklers. Based on interview at the time of observation, the Executive Director and Maintenance Director agreed the aforementioned areas were missing escutcheons. This deficient finding was reviewed with the Maintenance Director and Executive Director at the time of discovery and again at the exit conference at 3:45 p.m. 3. Based on observation, review and interview, the facility failed to ensure the installation of the sprinkler system met the requirements of NFPA 13. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition; Section 8.6.3.3 Minimum Distances from Walls. Sprinklers shall be located a minimum of 4 in. from a wall. This deficiency could impact 5 the staff in the laundry area. Findings include:		All residents with access to canvas canopy located outside “D” hall exit near room 57, all residents who have access to the corridor by business office manager and main entrance and all residents with access to the corridor outside of room 41 have the potential to be affected by the alleged deficiency. The staff who have access to the staff development office and the dryer room have potential to be affected by the alleged deficiency. The facility will add in sprinkler heads to the canvas canopy by 6/21/22, the facility will repair and/or replace sprinkler head escutcheons by 6/21/22. The facility will move the sprinkler head located in the dryer room by 6/21/22. The maintenance director or designee will work with contracted services to ensure that all items are completed by 6/21/22. The maintenance director or designee will complete rounds after installation and/or repairs. Any issues will be rectified immediately. What measures will be put into 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 to ensure that sprinkler heads and escutcheons are intact after installations and/or repairs. Any	

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	Based on observations during a tour of the facility with the Executive Director and Maintenance Director on 02/24/22 between 1:00 p.m. and 3:30 p.m., in the laundry area, the dryer room had a ceiling mounted sprinkler head installed within 1 inch of the side wall. The close proximity to the wall is noncompliant with the installation requirements of NFPA 13. Based on interview at the time of observation, the Maintenance Director stated the wall had been recently added. This deficient finding was reviewed with the Maintenance Director and Executive Director at the time of discovery and again at the exit conference at 3:45 p.m. 3.1-19(b)		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? 6/21/22	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source			

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	Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on observation and interview, the facility failed to ensure all sprinkler heads were not loaded or covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect 7 staff and 15 residents. Findings include: Based on observations during a tour of the facility with the Executive Director and Maintenance Director on 02/24/22 between 1:00 p.m. and 3:30 p.m., the following locations had sprinkler heads which were coved in dust or showed signs of loading. (A) 2 of 2 sprinkler heads in the conference room. (B) All sprinkler heads in the Dietary Managers Office (C) 1 of 1 sprinkler head in the "C" and "D" hall nurse's station. (D) 1 of 1 sprinkler head over the receptionist's desk near the main entry. This deficient finding was reviewed with the Maintenance Director and Executive Director at	K 0353	K353 Sprinkler System What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The facility removed the dust and/or signs of loading from sprinkler heads located in the conference room, the dietary managers office, the “C/D” Nurse’s station and the receptionist desk. The facility will acquire spare sprinklers for each type of sprinkler within the facility by 6/21/22. The facility is requesting a temporary waiver to acquire spare sprinklers, see attached for waiver request and intent from contracted company that will supply sprinklers. 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 who have access to areas with sprinkler heads have the potential to be affected by this alleged deficiency. All sprinkler heads inspected by maintenance director to ensure that they are not compromised by dust and/or have signs of loading. The facility will	06/21/2022

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	the time of discovery and again at the exit conference at 3:45 p.m. 2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were provided with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observations during a tour of the facility with the Executive Director and Maintenance Director on 02/24/22 between 1:00 p.m. and 3:30 p.m., there was one spare sprinkler cabinet in the riser room that included 6 spare sprinklers in their own protected slot. The provided spare sprinklers were all of one type. Multiple other types of sprinkler heads were observed during the facility tour which were not provided with spare replacements. The Maintenance Director agreed the spare sprinkler cabinet did not contain spare sprinkler heads for all types used in throughout the facility.		acquire spare sprinklers from contracted company by 6/21/22. What measures will be put into 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 to ensure that all sprinklers are free from dust and are not loaded. 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? 6/21/22	

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	This deficient finding was reviewed with the Maintenance Director and Executive Director at the time of discovery and again at the exit conference at 3:45 p.m. 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other 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			

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	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. 1. Based on observation and interview, the facility 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. Findings include: Based on observations during a tour of the facility with the Executive Director and Maintenance Director on 02/24/22 between 1:00 p.m. and 3:30 p.m., the (A) Maintenance Office corridor door, and (B) The Laundry Services corridor door near the Augustes Cottage entrance, equipped with a self-closing devices failed to close and latch positively into their respective door frames. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned corridor doors did not close and latch into the door frame and would not resist the passage of smoke. This deficient finding was reviewed with the Maintenance Director and Executive Director at the time of discovery and again at the exit conference at 3:45 p.m. 2. Based on observation and interview, the facility failed to ensure 1 of 1 set of double corridor doors	K 0363	F363 Corridor – Doors What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The facility has adjusted the corridor doors for the maintenance office and laundry services near the cottage so that they close and latch into the door frame. The facility will adjust the double corridor doors leading into the admissions office so that both sides latch appropriately. 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 maintenance office, the laundry services door and the admission's office have the ability to be affected by the alleged deficient practice. The maintenance director has inspected all doors to ensure that they close properly.	03/21/2022

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	would close completely and latch independently into the door frame. This deficient practice could affect 10 residents and staff near Admissions on Administrative hall. Findings include: Based on observations during a tour of the facility with the Executive Director and Maintenance Director on 02/24/22 between 1:00 p.m. and 3:30 p.m., the set of double corridor doors leading into the Admissions room required one door to latch with a manual assist and the other door would latch into stationary leaf, instead of both doors latching independently into their frame. An additional chain latch had been added however the added chain latch was not functioning properly. This deficient finding was reviewed with the Maintenance Director and Executive Director at the time of discovery and again at the exit conference at 3:45 p.m. 3.1-19(b)		What measures will be put into 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 to ensure that all doors close and latch into the door frames. 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? 3/21/22	
K 0511 SS=F Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas			

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	155230	A. BUILDING 01 B. WING	02/24/2022

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	Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure all electrical ceiling lights in the House Keeping Closet was protected from damage. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect 2 staff in the "A" Hall. Findings include: Based on observations during a tour of the facility with the Executive Director and Maintenance Director on 02/24/22 between 1:00 p.m. and 3:30 p.m., in the "A" Hall House Keeping Closet the ceiling light was missing a cover, exposing wires. The Maintenance Director stated he was previously unaware the light cover was missing. This deficient finding was reviewed with the Maintenance Director and Executive Director at the time of discovery and again at the exit conference at 3:45 p.m. 2. Based on observation, the facility failed to ensure 1 of 1 electrical tamper switch boxes in the Riser room were maintained in a safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition,	K 0511	K511 Utilities – Gas and Electric What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The facility has replaced the ceiling light cover in the housekeeping closet on “A” hall. The facility will replace the tamper switch cover in the sprinkler riser room by 6/21/22. The facility has secured a contractor to replace the tamper switch, see letter of intent. The facility is requesting a temporary waiver for the tamper switch cover replacement, see attached for temporary waiver request and intent to complete work by secured contractor. 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 the housekeeping closet and sprinkler riser room have the ability to be affected by the alleged deficiency. The maintenance director replaced the ceiling light cover in the housekeeping closet. The facility has secured a contractor to replace the tamper switch cover in the sprinkler riser room. The	06/21/2022

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	Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect all residents and staff. Findings include: Based on observations during a tour of the facility with the Executive Director and Maintenance Director on 02/24/22 between 1:00 p.m. and 3:30 p.m., the tamper switch electrical box attached to the sprinkler riser was missing its appropriate cover and had exposed electrical wiring hanging out of the box. This deficient finding was reviewed with the Maintenance Director and Executive Director at the time of discovery and again at the exit conference at 3:45 p.m. 3.1-19(b)		maintenance director will conduct rounds to ensure that all fixtures have covers on them, with no exposed wiring. 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 complete rounds to ensure that all fixtures have covers on them, with no exposed wiring. 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? 6/21/22	

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K 0741 SS=F 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 shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation, records review, and interview, the facility failed enforce 1 of 1 non-smoking policies. This deficient practice could affect all staff and visitors at the front entrance. Findings include:	K 0741	K741 Smoking Regulations What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The facility has removed the six cigarette butts in the landscaping	03/21/2022

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	Based on observations during a tour of the facility with the Executive Director and Maintenance Director on 02/24/22 between 1:00 p.m. and 3:30 p.m., smoking on property was evident due to at least 6 cigarette butts in the landscaping around the front entrance. The front entrance is not a designated smoking area however a smoker's tower was present near the landscaping. Based on interview with the Executive Director during records review she stated the smoking policy indicated that smoking is allowed in the facility's 1 designated smoking area, only staff are allowed to use the designated smoking area which is separated from the main building. This deficient finding was reviewed with the Maintenance Director and Executive Director at the time of discovery and again at the exit conference at 3:45 p.m. 3.1-19(b)		around the front entrance. 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 the entrance of the building have the ability to affected by the alleged deficient practice. The maintenance director removed the cigarette butts from the landscaping. 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 complete rounds to ensure that all cigarette butts are disposed of properly. Any issues will be immediately rectified. Maintenance director or designee with do a monthly walk through daily to ensure compliance. Executive director to monitor for compliance. The maintenance director or designee will educate staff on the facility smoking policy. 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	

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			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? 3/21/22	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen trans-filling rooms were separated from other areas in the facility in a room that is protected with a one-hour fire-resistive construction in accordance with 2012 NFPA 99 11.5.2.3.1(1). This deficient practice could affect 20 residents in one smoke compartment. Findings include:	K 0927	K927 Gas Equipment – Transfilling Cylinders What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The facility will install necessary drywall to meet the 1-hour protection requirement in the oxygen trans-filling room by	03/21/2022

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	Based on observations during a tour of the facility with the Executive Director and Maintenance Director on 02/24/22 between 1:00 p.m. and 3:30 p.m., the oxygen trans-filling room had side walls on 3 sides and by the door constructed with less than 1 hour of protection. Based on an interview at the time of observation, the Maintenance Director stated that they had recently learned that the drywall on the aforementioned walls was not sufficient thickness to meet the 1 hour requirement. A contractor has been secured to install the necessary drywall but has yet to begin or complete the work. This deficient finding was reviewed with the Maintenance Director and Executive Director at the time of discovery and again at the exit conference at 3:45 p.m. 3.1-19(b)		3/21/22. The facility has secured a contractor to provide work, see letter of intent. 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 the oxygen trans-filling room have the ability to affected by the alleged deficient practice. The facility will install necessary drywall to meet the 1-hour protection requirement in the oxygen trans-filling room by 3/21/22. The facility has secured a contractor to provide work. 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 ensure that work is completed on the oxygen trans-filling room by 3/21/22. The maintenance director or designee will complete audits to ensure that walls are intact. 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	

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			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? 3/21/22	