

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155329	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/09/2015
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NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219
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K 0000 Bldg. 01	<p>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).</p> <p>Survey Date: 07/09/15</p> <p>Facility Number: 000222 Provider Number: 155329 AIM Number: 100274950</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Rosewalk 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 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.</p> <p>This one story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. Battery operated smoke</p>	K 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after July 17th, 2015. Materials are being submitted with this plan of correction to support the providers request for a desk review. Documents are respectfully being submitted with the plan of correction to support providers request for paper compliance.	

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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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K 0018 SS=E Bldg. 01	<p>detectors are installed in all resident sleeping rooms. Smoke detectors hard wired to the fire alarm system are additionally installed in resident sleeping rooms 201 through 211. The facility has a capacity of 161 and had a census of 151 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except two detached wooden sheds providing facility storage.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 78 resident sleeping room corridor doors were provided with a means suitable for</p>	K 0018	<ol style="list-style-type: none"> The door was adjusted so that it closes and latches into the frame and would resist the passage of smoke. Residents on F hall, staff, and 	07/17/2015

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	<p>keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 28 residents, staff and visitors in the vicinity of Room 153.</p> <p>Findings include:</p> <p>Based on observation with the Senior Administrator, the Assistant Administrator and the Maintenance Director during a tour of the facility from 11:15 a.m. to 1:40 p.m. on 07/09/15, the corridor door to Room 153 failed to latch into the door frame because the door was prevented from fully closing by the thickness of the paint layers on the hinge side of the door. The aforementioned corridor door failed to fully close and latch into the door frame after repeated attempts to pull the door shut. Based on interview at the time of observation, the Senior Administrator stated the corridor door to Room 153 was recently painted and acknowledged the aforementioned corridor door had an impediment to closing and latching into the door frame.</p> <p>3.1-19(b)</p>		<p>visitors had the potential to be affected by this alleged deficient practice.</p> <p>3. All doors have been inspected to ensure they close and latch into the frame and resist the passage of smoke. Any new door installed will be inspected to ensure they close and latch into the frame</p> <p>4. Facility maintenance director will audit weekly for 4 weeks, and then monthly for 5 months to ensure that all existing doors close and latch into the frame and resist the passage of smoke. Results of audits will be taken to facility monthly CQI meeting for review</p> <p>5. Maintenance director is responsible. Completion date 7/17/15.</p>	

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K 0025 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect two staff in the laundry.</p> <p>Findings include:</p> <p>Based on observation with the Senior Administrator, the Assistant Administrator and the Maintenance Director during a tour of the facility from 11:15 a.m. to 1:40 p.m. on 07/09/15, the two inch annular space surrounding two separate one inch in diameter natural gas pipes and the one and a half inch annular space surrounding each of two one inch in diameter conduits which penetrated the ceiling of the area behind the dryers in</p>	K 0025	<p>1. Both of the one inch annular spaces surrounding the gas pipes and conduits in the dryer area were filled with fire caulk.2. Staff, residents on B hall or visitors had the potential to be affected by this alleged deficient practice. Both of the one inch annular spaces surrounding the gas pipes and both of the spaces surrounding the conduits in the dryer area were filled with fire caulk.3. All natural gas pipes and conduit were inspected to ensure they were appropriately sealed with fire caulk. Maintenance supervisor or designee will be present when gas lines or conduit are installed to ensure they are appropriately fire caulked.4. All gas lines and conduit will be inspected monthly for 6 months to ensure fire caulk is intact. Results of audits will be taken to facility monthly CQI meeting for</p>	07/17/2015
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K 0029 SS=D Bldg. 01	<p>the laundry were each not filled with an approved material to provide at least a one half hour fire resistance rating. Based on interview at the time of observation, the Senior Administrator acknowledged the aforementioned holes in the laundry dryer area ceiling smoke barrier did not maintain at least a one half hour fire resistance rating.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48</p>		<p>review. 5. Maintenance director is responsible. Completion date 7/17/15</p>	

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	<p>inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 18 hazardous areas such as fuel fired heater rooms were separated from other spaces by smoke resistant partitions. This deficient practice could affect two staff in the laundry.</p> <p>Findings include:</p> <p>Based on observation with the Senior Administrator, the Assistant Administrator and the Maintenance Director during a tour of the facility from 11:15 a.m. to 1:40 p.m. on 07/09/15, the two inch annular space surrounding two separate one inch in diameter natural gas pipes and the one and a half inch annular space surrounding each of two one inch in diameter conduits which penetrated the ceiling of the area behind the natural gas fired dryers in the laundry were each not filled with an approved material to separate this hazardous area from other spaces with smoke resistant partitions. Based on interview at the time of observation, the Senior Administrator acknowledged the aforementioned holes in the laundry dryer area ceiling smoke barrier were each not filled with an approved material to separate this hazardous area from other spaces with</p>	K 0029	<p>1. Both of the one inch annular spaces surrounding the gas pipes and conduits in the dryer area were filled with fire caulk.2. Staff, residents on B hall or visitors had the potential to be affected by this alleged deficient practice. Both of the one inch annular spaces surrounding the gas pipes and surrounding the conduits in the dryer area were filled with fire caulk.3. All natural gas pipes and conduits were inspected to ensure they were appropriately sealed with fire caulk. Maintenance supervisor or designee will be present when gas lines or conduits are installed to ensure they are appropriately fire caulked.4. All gas lines will be inspected monthly for 6 months to ensure fire caulk is intact. Results of audits will be taken to facility monthly CQI meeting for review. 5. Maintenance director is responsible. Completion date 7/17/15</p>	07/17/2015

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K 0050 SS=F Bldg. 01	<p>smoke resistant partitions.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to document fire drills conducted on the first shift for 1 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Monthly Fire Drill Report" documentation with the Senior Administrator, the Assistant</p>	K 0050	<ol style="list-style-type: none"> 1. Fire drills have been held for all shifts, with appropriate time staggering, since January 2015. 2. All residents, staff, and visitors had the potential to be affected by this alleged deficient practice. Fire drills have been held for all shifts, with appropriate time staggering, since January 2015. 3. A fire drill will be held at unexpected times under varying conditions, at least quarterly on each shift. 4. Monthly audit will be conducted for 6 months to ensure 	07/17/2015

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K 0056 SS=D Bldg. 01	<p>Administrator and the Maintenance Director during record review from 9:15 a.m. to 11:15 a.m. on 07/09/15, documentation of a fire drill conducted on the first shift in the fourth quarter of 2014 was not available for review. Documentation for fire drills conducted in the fourth quarter on 10/23/14 at 3:10 p.m., on 11/25/14 at 10:00 p.m. and at 12/31/14 at 5:15 a.m. was documented as second or third shift fire drills. Based on the exit interview at 2:00 p.m., the Senior Administrator acknowledged none of the three aforementioned fourth quarter 2014 fire drills were documented as a first shift fire drill and acknowledged documentation of a fire drill conducted on the first shift in the fourth quarter of 2014 was not available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water</p>				<p>fire drills will be held at unexpected times under varying conditions, at least quarterly on each shift. Results of audits will be taken to facility monthly CQI meeting for review.</p> <p>5. Executive director or assistant executive director is responsible. Completion date 7/17/15</p>		

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	<p>flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was installed in accordance with the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 5-6.5 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-6.5.2 and 5-6.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. This deficient practice could affect two staff in the laundry.</p> <p>Findings include:</p> <p>Based on observation with the Senior Administrator, the Assistant Administrator and the Maintenance Director during a tour of the facility from 11:15 a.m. to 1:40 p.m. on 07/09/15, the area behind the dryers in the laundry is provided with one pendant sprinkler which protrudes one foot from the front wall into the area behind the dryers. Each dryer located below the pendant sprinkler blocks the installed sprinkler from providing sprinkler coverage to the entire area behind the dryers. Based on interview at the time of observation, the Senior Administrator acknowledged the</p>	K 0056	<ol style="list-style-type: none"> The fire pendant sprinkler was extended to ensure proper coverage in the dryer area. Residents on B hall, staff, and visitors had the potential to be affected by this alleged deficient practice. All sprinkler pendants in the laundry room have been inspected to ensure there is proper coverage for affected machinery. Facility maintenance director will audit weekly for 4 weeks, and then monthly for 5 months to ensure that all existing or newly installed machinery has proper coverage with sprinkler pendants. Results of audits will be taken to facility monthly CQI meeting for review Maintenance director is responsible. Completion date 7/17/15. 	07/17/2015

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K 0062 SS=D Bldg. 01	<p>aforementioned pendant sprinkler was not positioned to ensure adequate coverage for the entire area behind the dryers in the laundry.</p> <p>3.1-19(b) 3.1-19(ff)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to replace 1 of over 100 sprinklers which had become corroded, had paint, lint or other foreign materials on them. LSC 9.7.5 requires all automatic sprinkler systems shall be</p>	K 0062	<p>1. The fire pendant sprinkler that was covered in lint was cleaned on 7/9/15. It was also replaced due to being affixed to the fire pendant sprinkler that was replaced in K056.</p> <p>2. Residents on B hall, staff, and</p>	07/17/2015

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	<p>inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect two staff in the laundry.</p> <p>Findings include:</p> <p>Based on observation with the Senior Administrator, the Assistant Administrator and the Maintenance Director during a tour of the facility from 11:15 a.m. to 1:40 p.m. on 07/09/15, the one pendant sprinkler which protrudes one foot from the front wall into the area behind the dryers in the laundry was covered with lint. Based on interview at the time of observation, the Senior Administrator acknowledged the aforementioned sprinkler was covered with lint.</p> <p>3.1-19(b)</p>		<p>visitors had the potential to be affected by this alleged deficient practice.</p> <p>3. All sprinkler pendants in the laundry room have been inspected to ensure they are not painted, corroded, damaged, loaded, or in the improper orientation.</p> <p>4. Facility maintenance director will audit weekly for 4 weeks, and then monthly for 5 months to ensure that all existing or newly installed machinery has proper coverage with sprinkler pendants. Results of audits will be taken to facility monthly CQI meeting for review</p> <p>5. Maintenance director is responsible. Completion date 7/17/15.</p>		

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K 0067 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on record review and interview, the facility failed to ensure all fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire/Smoke Damper Maintenance Record" documentation dated 03/29/11 with the Senior</p>	K 0067	<ol style="list-style-type: none"> All fire dampers were inspected on 7/15/15. All residents, staff, and visitors had the potential to be affected by this alleged deficient practice. All fire dampers were inspected on 7/15/15, to ensure they did not allow the passage of smoke from one fire compartment to the next fire compartment. Facility maintenance director will audit yearly, or more frequently if needed, to ensure that inspections of dampers occur at a minimum every four years. Results of audits will be taken to facility monthly CQI meeting for review Maintenance director is responsible. Completion date 7/17/15. 	07/17/2015

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	<p>Administrator, the Assistant Administrator and the Maintenance Director during record review from 9:15 a.m. to 11:15 a.m. on 07/09/15, documentation of fire damper inspection and maintenance performed within the most recent four year period for twenty facility fire dampers was not available for review. Based on interview at the time of record review, the Maintenance Director stated fire dampers are installed in the facility, fire damper maintenance is scheduled to be performed 07/20/15 and acknowledged documentation of fire damper inspection and maintenance performed within the most recent four year period was not available for review.</p> <p>3.1-19(b)</p>				