

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155829	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  05/11/2016
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NAME OF PROVIDER OR SUPPLIER  SPRINGS AT LAFAYETTE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2402 SOUTH STREET LAFAYETTE, IN 47904
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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: 05/11/16</p> <p>Facility Number: 013499 Provider Number: 155829 AIM Number: 201285490</p> <p>At this Life Safety Code survey, The Springs at Lafayette 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 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, all areas open to the corridors, and all resident rooms with hard wired smoke detectors. The facility has a capacity of 70 and had a census of 53 at the time of this visit.</p>	K 0000		
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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>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure 4 of 6 corridor doors on Administrative hall would latch into its frame. This deficient practice could affect 7 residents on Administrative hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observations on 05/11/16 during the tour between 11:30 p.m. to 12:10 p.m. with the Maintenance Supervisor, the corridor doors leading into the Therapy Gym, Theatre room, Beauty Shop and Sitting room on the</p>	K 0018	<p>All doors cited in survey will have positive latching hardware installed that will be connected to each respective door frame.</p> <p>This alleged deficient practice could affect 7 residents on Administrative hall as well as visitors and staff. Doors cited will have latching hardware installed that will allow each door to be latched appropriately to the doorframe, meeting life safety code standards.</p> <p>DPO or designee will inspect and document weekly for 6 months the latches are secure and functional. QA will monitor for any trends and</p>	07/13/2016

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K 0025 SS=E Bldg. 01	<p>Administrative hall did not have any latching devices on the doors and therefore, would not latch into their frames. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned resident use rooms would not latch into their frames because of a lack of latching hardware.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 6 smoke barriers was protected to maintain the one half hour fire resistance rating of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire be protected, so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could</p>	K 0025	<p>will make recommendations to the POC as needed.</p> <p>3M brand Fire Barrier Sealant, 150+ Flexible, Red Fire Caulk purchased and used to caulk openings on both sides of the bulkhead area. All residents, staff and visitors residing on Assisted Living have the potential to be affected by this alleged deficient practice. Director of Plant Operations (DPO) has installed the appropriate fire rated caulk to this specific area. DPO or designee will check on a weekly basis for next 6 months to ensure that caulk is adhered and still intact.</p>	06/10/2016

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K 0056 SS=E Bldg. 01	<p>affect 7 residents on Administrative hall, if smoke from a fire were to infiltrate the protective barrier.</p> <p>Findings include:</p> <p>Based on observation on 05/11/16 at 3:00 p.m. with the Maintenance Supervisor the smoke wall separating Assisted Living from the Administrative hall had a one inch opening on the left side of a four inch diameter pipe which penetrated the smoke wall and which was not firestopped. Based on interview on 05/11/16 concurrent with the observation with the Maintenance Supervisor, it was acknowledged the aforementioned smoke barrier wall had an opening which was not filled with a fire rated material to maintain a one half hour fire resistance rating.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system installed in accordance with NFPA13, Standard for the Installation of Sprinkler Systems, with approved components, device and equipment, to provide complete coverage of all portions of the facility. Systems are equipped with waterflow and tamper switches, which are connected to the fire alarm system. In Type I and II construction, alternative protection measures shall be permitted to be</p>		QA will monitor for any trends and will make recommendations to the POC as needed.				

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	<p>substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 18.3.5, 18.3.5.1.</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 4 steel armover sprinkler pipes observed in the Riser room was installed in accordance with the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 6-2.3.4 states the cumulative horizontal length of an unsupported armover to a sprinkler, sprinkler drop, or sprig-up shall not exceed 24 inches for steel pipe or 12 inches for copper tube. This deficient practice could affect all residents in the building if the sprinkler system required repair as well as staff or visitors.</p> <p>Findings include:</p> <p>Based on observation on 05/11/16 at 2:15 p.m. with the Maintenance Supervisor, the steel sprinkler pipe armover observed exposed above the light fixture in the Riser room was measured to be four feet in length and unsupported.</p> <p>Based on interview on 05/11/16 concurrent with the observation with the Maintenance Supervisor it was acknowledged the aforementioned steel sprinkler pipe armover exceeded twenty four inches in length and was</p>	K 0056	<p>Repair to sprinkler system will be completed Friday June 3rd, by Hydro company representatives. Existing fire suppression system will be updated to NFPA 13 2010 edition requirements. Dock area pendent sprinkler will be relocated along with the horizontal sidewall head so that they are both 6 feet apart. All staff, visitors and residents residing in facility have the potential to be affected by this alleged deficient practice. Sprinkler systems will be inspected quarterly by our contracted sprinkler service provider. Sprinkler systems will be inspected quarterly by our contracted sprinkler service provider.</p> <p>QA will monitor for any trends and will make recommendations to the POC as needed.</p>	06/10/2016

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K 0130 SS=E Bldg. 01	<p>unsupported.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure sprinkler heads were spaced a minimum of 6 feet apart for 1 of 1 automatic sprinkler systems. NFPA 13, Section 5-6.3.4, "Minimum Distance between Sprinklers", states sprinklers shall be spaced not less than 6 feet on center. This deficient practice could affect 8 residents observed on South hall adjacent to Service hall as well as staff or visitors.</p> <p>Findings include:</p> <p>Based on observation on 05/11/16 at 1:59 p.m. with the Maintenance Supervisor, two pendant sprinkler heads located in the ceiling of the Dock lobby on Service hall was measured to be three feet apart. Based on interview concurrent with the observation with Maintenance Supervisor, it was acknowledged the aforementioned sprinkler heads observed were less than six feet apart.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS Miscellaneous</p>				

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	<p>List in the REMARKS sections, any items that are not listed previously, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.THER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 nonflammable gas cylinders was properly chained or supported in a cylinder stand or cart while in storage. LSC 2.1.1 references NFPA 99, Health Care Facilities. NFPA 99, 8-3.1.11.2(h) requires cylinder or container restraint shall meet NFPA 99, 4-3.5.2.1(b) 27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect 7 residents observed on Administrative hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 05/11/16 at 12:20 p.m. with the Maintenance Supervisor the helium cylinder located in the closet of the Community room located on Administrative hall was free standing without being chained or supported in a cylinder stand or cart. Based on interview on 05/11/16 at 12:22 p.m. with the Maintenance Supervisor it</p>	K 0130	<p>A chain has been fastened to 2 wall studs, 16 inches apart, with both ends of this chain joined together from each stud with a double-ended spring loaded fastener clip, wrapped around the helium tank, and thus safely securing the helium tank to the wall.</p> <p>This alleged deficient practice could affect 7 residents observed on Administrative hall as well as visitors and staff. Helium tank has been secured to wall to help prevent any falls of the tank. DPO or designee will inspect and document this item monthly for 6 months for any defection. QA will monitor for any trends and will make recommendations to the POC as needed.</p>	06/10/2016
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K 0144 SS=F Bldg. 01	<p>was acknowledged the helium cylinder should have been in a rack or properly secured with a chain.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>Based on observation and interview, the facility failed to provide emergency task lighting in and around 1 of 1 generator sets in accordance with NFPA 101, 2000 Edition, Life Safety Code. LSC Section 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110 Section 5-3.1 requires the EPS (Emergency Power Supply) equipment location shall be provided with battery powered emergency lighting. This deficient practice could affect all residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 05/11/16 at 2:15 p.m. with the Maintenance Supervisor,</p>	K 0144	<p>A Lithonia Wet Location Emergency light with battery and charger has been installed with battery back-up capability.</p> <p>All residents as well as staff and visitors could be affected by this alleged deficiency. DPO has installed the appropriate equipment with battery powered emergency lighting.</p> <p>DPO or designee will inspect and document this light's functionality and will perform testing on a monthly basis. QA will monitor for any trends and will make recommendations to the POC as needed.</p>	06/10/2016

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K 0147 SS=D Bldg. 01	<p>the generator set location outside exit 17 lacked battery powered emergency lighting in or around the generator. Based on interview 05/11/16 at 2:19 p.m., it was acknowledged by the Maintenance Supervisor there was no battery powered emergency light available for the generator.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 1 of 1 extension cords observed including surge protectors, non-fused extension cords and/or multiplug adapters was not used as a substitute for fixed wiring. NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 25 residents on 300 hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 05/11/16 at 12:30 p.m. with the Maintenance Supervisor an extension cord was used to</p>	K 0147	<p>On 5/27/16, electrical contractor furnished and installed MC cable type wiring, MC connectors, junction boxes, straps, fittings and power terminations for new circuit extension from sink receptacle to (1) double duplex GFCI receptacle cut in beauty cabinet for stylist receptacles.</p> <p>This alleged deficient practice could affect 25 residents on the 300 hall as well as visitors and staff. Corrective action by electrical contractor will ensure fixed wiring is utilized in this area.</p> <p>DPO or designee will inspect and document weekly for 6 months that proper wiring is being utilized in this area. QA will monitor for any trends and will make recommendations to the POC as needed.</p>	06/10/2016

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	provide power to cutting shears in the Beauty shop on Administrative hall. Based on interview on 05/11/16 concurrent with the observation it was acknowledged by the Maintenance Supervisor, an extension cord was used to power the aforementioned electrical appliance.  3.1-19(b)				