

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155121	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/13/2015
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NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT LAFAYETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION ST 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: 07/13/15</p> <p>Facility Number: 000051 Provider Number: 155121 AIM Number: 100275490</p> <p>At this Life Safety Code survey, Rosewalk Village 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 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This facility consists of the original two story building with a one story section on the front and a one story Physical Therapy wing added to the first floor D wing and is fully sprinklered. The construction was determined to be of Type III (211) and completed prior to March 1, 2003. The facility has a fire alarm system with smoke detection in the</p>	K 0000	Rosewalk Village of Lafayette respectfully requests desk review for this survey	
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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 0038 SS=E Bldg. 01	<p>corridors, and spaces open to the corridors. The facility has battery operated smoke detectors in resident sleeping rooms. The facility has a capacity of 141 and had a census of 126 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has two detached equipment storage buildings which were not sprinklered.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure exit access was arranged so 1 of 7 exits was readily accessible at all time. LSC Section 7.1.6.3 states walking surfaces shall be nominally level. The slope of a walking surface in the direction of travel shall not exceed 1 in 20 inches. LSC Section 7.2.2.4.2 requires handrails shall be provided along both sides of a ramp. LSC Section 7.2.2.4.2 Exception #3 requires that an existing ramp shall have a handrail on at least one side. This deficient practice could affect 25 residents on Memory Care wing if it was</p>	K 0038	<p>1) No residents were affected. Handrails will be installed at this exit2) All residents residing on the Memory Care unit have the potential to be affected. Handrails will be installed at this exit3) All exits have been assessed and meet the criteria. Any changes made to any exit in the future will be assessed to ensure the exit meets the accessibility criteria4) The CQI committee will receive the completed assessment from the maintenance department with changes to any exits to ensure the exit meets the accessibility criteria for a minimum of 6 months. If 100% threshold is not achieved, an action plan will be</p>	08/10/2015

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K 0051 SS=E Bldg. 01	<p>necessary to use the ramp exit to evacuate the building as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 07/13/15 at 1:45 p.m., with the Maintenance Supervisor the exit discharge ramp next to resident room #113 on Memory Care wing lacked handrails. The cement ramp was four feet wide by fifteen feet long and was measured with the Maintenance Supervisor to have a slope of four and one half inches drop to forty eight inches of walkway. Based on interview concurrent with measurement with the Maintenance Supervisor it was confirmed the slope exceeded one in twenty inches and no handrails were provided.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's</p>		<p>developed to ensure compliance</p> <p>5) All corrective actions will be completed by 8/10/15</p>		

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	<p>stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 smoke detectors on Memory Care wing was installed in a location which would allow the smoke detector to function to its fullest capability. NFPA 72, 2-3.5.1 requires, in spaces served by air handling systems, detectors shall not be located where air flow inhibits operation of the detectors. This deficient practice could affect 25 residents on Memory Care as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 07/13/15 at 1:55 p.m. with the Maintenance Supervisor, the smoke detector next to resident room #110 on Memory Care wing was directly above a ceiling fan which was in operation at the time of observation.</p> <p>Based on interview on 07/13/15 at 1:56 p.m. with the Maintenance Supervisor, it was acknowledged the aforementioned smoke detector was installed above an operating ceiling fan which would interfere with the smoke detector's ability</p>	K 0051	<p>1) No residents were affected. The identified smoke detector will be moved away from the ceiling fan to allow optimum function2) All residents residing on memory care have the potential to be affected. The identified smoked detector will be moved away from the ceiling fan to allow optimum function3) The smoke detector will be moved away from the ceiling fan to allow optimum function. All smoke detectors were assessed to ensure they meet the criteria for optimum functioning4) The CQI committee will receive the completed assessment from the maintenance department with any changes to any smoke detectors to ensure the detector meets the criteria for optimum functioning for a minimum of 6 months. If 100% threshold is not achieved, an action plan will be developed to ensure compliance5) All corrective actions will be completed by 8/10/15</p>	08/10/2015			

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K 0147 SS=E Bldg. 01	<p>to detect smoke to its fullest capability.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 extension cords observed including non-fused extension cords and/or multiplug adapters were not used to power kitchen appliances. NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires that, 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 16 residents in Moving Forward wing as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 07/13/15 at 2:00 p.m. a 14/3 gauge wire extension was used to provide power to a plate warmer with a 10 gauge connection cord in the kitchen instead of a direct connection into a wall outlet. Based on interview on</p>	K 0147	<p>1) no residents were affected. A 10-12 guage service cord for the plate warmer will be installed and directly connected to the wall outlet. 2) All residents residing on the Moving Forward wing, staff and visitors have the potential to be affected. A 10-12 guage service cord for the plate warmer will be installed and directly connected to the wall outlet. 3) A 10-12 guage service cord for the plate warmer will be installed for the plate warmer and directly connected to the wall outlet. All other cords were assessed to ensure they meet the National Electric code. 4) The CQI committee will receive an audit tool from the maintenance department for a minimum of 6 months to ensure all electrical powered equipment meets the National Electric code. If 100% threshold is not achieved, an action plan will be developed to ensure complaince 5) All corrective actions will be completed by 8/10/15</p>	08/10/2015

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	07/13/15 concurrent with the observation it was acknowledged by the Maintenance Supervisor, the 10 gauge service cord for the plate warmer should have been connected into a wall outlet. 3.1-19(b)				