

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 05/10/2016
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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: 05/10/16</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		

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 0025 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 122 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>Quality Review completed on 05/13/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half 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 and steel frames. 8.3, 19.3.7.3, 19.3.7.5 Based on observation and interview, the facility failed to ensure 1 of 2 smoke barriers on the second floor 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</p>	K 0025	No residents were found to have been affected. The smokewall on the 200 south hall second floor has been corrected and meets the one half hour fire resistance rating. Residents having the potential to be affected are those residents residing on 200 south hall second floor. The smokewall on the 200 south hall second floor has been corrected and meets the one half hour fire resistance rating. All smokewalls have	05/30/2016

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K 0056 SS=F Bldg. 01	<p>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 affect 10 residents on South hall if smoke from a fire were to infiltrate the protective barrier.</p> <p>Findings include:</p> <p>Based on observation on 05/10/16 at 3:00 p.m. with the Maintenance Supervisor, the smokewall on 200 south hall second floor had a fist size hole at the upper left and lower right portion of the smoke barrier which were not firestopped.</p> <p>Based on interview on 05/10/16 concurrent with the observation with the Maintenance Supervisor, it was acknowledged the aforementioned smoke barrier wall had openings which were 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 Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper</p>		<p>been observed to ensure the one half hour fire resistance rating is met. Maintenance or designee will continue to observe smokewalls quarterly or more often as needed, to ensure the one half hour fire resistance rating continues to be met. A CQI tool will be completed following each observation of the smokewall and submitted to CQI committee for evaluation for 1year. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance. All corrective actions will be completed on or before 5/30/16.</p>				

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	<p>switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 steel armover sprinkler pipes observed in the Memory Care lounge 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 05/10/16 at 2:15 p.m. with the Maintenance Supervisor, the metal sprinkler pipe located at the west wall of the Memory Care lounge on second floor was observed to be at least four feet in length and was unsupported. Based on interview on 05/10/16 concurrent with the observation with the</p>	K 0056	<p>No residents were found to have been affected. The steel armover sprinkler pipe has been corrected in the Memory Care Lounge. All residents in the building have the potential to be affected. The steel armover pipe has been corrected in the Memory Care Lounge. All sprinkler pipes have been observed to ensure they are properly installed. Maintenance or designee will continue to observe sprinkler pipes throughout the building quarterly or more often as needed, to ensure they are properly installed. A CQI tool will be completed following each observation of the sprinkler pipes and submitted to the CQI committee for 1 year. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance. All corrective actions will be completed on or before 5/30/16.</p>	05/30/2016

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K 0064 SS=E Bldg. 01	<p>Maintenance Supervisor, it was acknowledged the aforementioned steel sprinkler pipe armover exceeded twenty four inches in length and was unsupported.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6</p> <p>Based on observations and interview, the facility failed to ensure 1 of 17 portable fire extinguishers on the first floor was installed correctly. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.10 requires the top of portable fire extinguishers weighing 40 pounds or less should be no more than five feet (60 inches) above the floor and those weighing more than 40 pounds should be not more than three and one half feet (42 inches) above the floor. This deficient practice could affect 8 residents observed in the first floor Dining room as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 05/10/16 at 1:35 p.m. with the Maintenance Supervisor,</p>	K 0064	<p>No residents were found to have been affected. The fire extinguisher in the first floor dining room has been lowered to meet the five feet requirement. All residents or visitors in the first floor dining room have the potential to be affected. The fire extinguisher in the first floor dining room has been lowered to meet the five feet requirement. All fire extinguishers in the building have been checked to ensure they meet the requirement. Maintenance or designee will check all fire extinguishers quarterly or more often as needed, to ensure the 5 feet requirement is met. A CQI tool will be completed following each observation of the fire extinguishers and submitted to the CQI committee for 1 year. If threshold of 95% is not achieved, an action plan will be developed</p>	05/30/2016

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K 0070 SS=E Bldg. 01	<p>the fire extinguisher in the first floor Dining room adjacent to the kitchen was measured to be installed with the top of the fire extinguishers at seventy two inches from the floor. Based on interview on 05/10/16 concurrent with the observation with the Maintenance Supervisor, it was acknowledged the aforementioned portable fire extinguisher was over sixty inches from the floor.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8</p> <p>Based on observation, interview and record review, the facility failed to regulate the use of 1 of 1 portable space heaters observed in non-resident rooms. This deficient practice could affect 18 residents on first floor Moving Forward hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 05/10/16 at 2:15 p.m. with the Maintenance Supervisor, one portable space heater was plugged in</p>	K 0070	<p>to ensure complinace. All corrective actions will be completed on or before 5/20/16.</p> <p>No residents were found to have been affected. The space heater was immediately removed from the facility. The residents residing on the Moving Forward unit had the potential to be affected. The space heater was immediatley removed from the facility. Facility staff were re-inserviced on the disaster plan which states "space heaters may not be used in any area of the facility." Maintenance or designee will observe facility for use of space heaters quarterly or more often as needed. A CQI tool will be completed</p>	05/30/2016

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K 0143 SS=E Bldg. 01	<p>and being used in the front Reception area adjacent to Moving Forward hall on first floor. Based on interview on 05/10/16 concurrent with the observation, it was acknowledged by the Maintenance Supervisor, the portable heater was not allowed in the facility and no documentation pertaining to the portable space heater was available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association.</p> <p>8-6.2.5.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 2 oxygen storage rooms where liquid oxygen transfer occurs had continuously</p>	K 0143	<p>following each observation for space heater use and submitted to the CQI committee for 1 year. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance. All corrective actions will be completed on or before 5/30/16.</p> <p>No residents were found to have been affected. The electrically powered mechanical ventilation has been repaired and is continuously working. Residents</p>	05/30/2016			

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K 0147 SS=E Bldg. 01	<p>working, electrically powered mechanical ventilation. This deficient practice could affect 10 residents as well as visitors and staff on 100 south hall first floor.</p> <p>Findings include:</p> <p>Based on observation on 05/10/16 at 1:40 p.m. with the Maintenance Supervisor, the first floor oxygen storage room on 100 hall south used to store and transfer liquid oxygen was provided with electrically powered mechanical ventilation, but it was not working. Based on interview concurrent with the observation, it was acknowledged by the Maintenance Supervisor, the oxygen room was used to transfer liquid oxygen and the electrically powered mechanical vent was not working.</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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 6 powerstrips observed including extension cords and non-fused multiplug adapters were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.1 requires</p>	K 0147	<p>and visitors on 100 shouth hall, 1st floor have the potential to be affected. The electrically powered mechanical ventilation has been repaired and is continously working. Maintenance or designee will observe the electrically powered ventilaton in both oxygen storage rooms to ensure they are continually working quarterly and as needed. A CQI tool will be completed following each observation of the electrically powered mechanical ventilation and submitted to the CQI committee for 1 year. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance. All corrective actions will be completed on or before 5/30/16.</p> <p>No residents were found to have been affected. The surge protector was removed and no longer in use. Residents and visitors on 200 hall north, second floor have the potential to be affected. The surge protector was removed and no longer in use. All refrigerators have been checked</p>	05/30/2016

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	<p>electrical wiring and equipment to comply with 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 would affect 8 residents on 200 hall north, second floor as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 05/10/16 at 2:50 p.m. with the Maintenance Supervisor, there was a full size refrigerator plugged into a surge protector in the Staff Coordinator's office on 200 hall north, second floor. Based on interview with the Maintenance Supervisor at the time of observation, it was acknowledged a surge protective device was used to power a full size refrigerator in the Staff Coordinator's office on second floor.</p> <p>3.1-19(b)</p>		<p>to ensure surge protectors are not in use. Staff have been re-inserviced on the policy in the disaster plan which states "power strip cords will not be used for resident refrigerators" nor can they be utilized for any refrigerators. Maintenance or designee will check refrigerators in the building quarterly or more often as needed to ensure surge protectors or power strips are not in use. A CQI tool will be completed following each observation of the refrigerators and submitted to the CQI committee for evaluation quarterly for 1 year. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance. All corrective actions will be completed on or before 5/30/16.</p>				