STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155322	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 11/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K0000	A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 11/07/12 Facility Number: 000215 Provider Number: 155322 AIM Number: 100267600 Surveyor: Joe L Brown Jr., Life Safety Code Specialist At this Life Safety Code survey, Renaissance Village was found in not 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. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridor, and battery operated smoke detectors in forty	K0000	The following Plan of Correction (POC) constitutes our written allegation of compliance for the deficiencies cited. Submission of the POC is not an admission that a deficiency exists or that one was cited correctly. This POC is submitted to meet requirements established by state and federal law.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	resident rooms with hard wired smoke detectors in resident rooms 309 through 317. The facility has a capacity of 96 and had a census of 81 at the time of this survey. The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/15/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0039 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 Based on observation and interview, the facility failed to ensure 1 of 4 exit access corridors had a clear and unobstructed exit width of at least 4 feet (48 inches). This deficient practice had the potential to affect 32 residents in the 200 hall corridor in the event of an emergency evacuation. Findings include: Based on observation on 11/07/12 with the Maintenance Supervisor during the tour from 9:30 a.m. to 12:38 p.m., there was a utility cart, wheel chair, and a weight scale on both sides of the 200 hall corridor decreasing the corridor width to less than forty eight inches. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)	K0039	**CORRECTIVE ACTION FOR AFFECTED RESIDENTS** Al l items and equipment were moved to only one side of the 200 hallway to allow for proper clearance of at least 48 inches. **IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS** All halls were checked for proper clearance and items/equipment were relocated to only one side of the hall to allow for at least 48 inches of clearance **MEASURES FOR PREVENTION** *Employees were in-serviced regarding proper corridor clearance and equipment location on only one side of hall. Environmental staff will monitor and log hallways weekly for proper clearance (See Appendix B).* ***QA FOR PREVENTION*** *Environmental Services Manager to review Preventative Maintenance logs monthly for completion and report findings to QA committee monthly.* ***EFFECTIVE DATE*** *The changes are completed and effective by December 7, 2012.*	12/07/2012

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