

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  06/24/2013
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NAME OF PROVIDER OR SUPPLIER  ROSEWALK VILLAGE AT INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219
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(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
K010000	<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: 06/24/13</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 at Indianapolis 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>	K010000	<p>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.</p> <p>This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a Desk review on or after 7/9/13.</p>	

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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	<p>detectors are installed in all resident sleeping rooms. The facility has a capacity of 161 and had a census of 141 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>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/27/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010017 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 open use areas was separated from the corridor, or met an Exception. LSC 19.3.6.1, Exception # 1, Spaces shall be permitted to be unlimited in area and open to the corridor, provided the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke</p>	K010017	<ol style="list-style-type: none"> <li>An electronically supervised automatic smoke detector will be installed in the receptionist office.</li> <li>Residents on G hall, staff, and visitors had the potential to be affected by this alleged deficient practice. An electronically supervised automatic smoke detector will be installed in the receptionist office</li> <li>Any new offices or areas created that have a need for an electronically supervised automatic smoke detector will have one installed prior to use.</li> <li>Facility maintenance director will audit weekly for 4 weeks, and then monthly for 5 months to ensure that any new areas or office space have appropriate electronically supervised automatic smoke detectors installed prior to use. Results of audits will be taken</li> </ol>	07/09/2013
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	<p>detection system in accordance with 19.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. This deficient practice could affect 20 residents, staff and visitors adjacent to the Reception office by the Main entrance.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 10:45 a.m. to 2:00 p.m. on 06/24/13, the Reception office next to the Main Entrance had a wooden accordion door which was not positive latching separating the office from the corridor and it was open to the corridor at the time of observation. Exception # 1, requirement (c) of the Life Safety Code, Chapter 19.3.6.1 was not met as follows: the open area was not protected by an automatic smoke detection system or arranged to allow direct supervision by facility staff from a continuously staffed area such as a nurses' station. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the Reception office was open to the corridor without supervision from the nurse's station and was not protected by automatic smoke detection.</p>		<p>to facility monthly CQI meeting for review</p> <p>5. Maintenance director is responsible. Completion date 7/09/13.</p>		

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	3.1-19(b)			

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K010025 SS=B	<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 openings through 1 of 6 smoke barrier walls were protected to maintain the one half hour smoke resistance of the smoke barrier. This deficient practice could affect 5 staff or visitors in vicinity of Mechanical Room #5.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 10:45 a.m. to 2:00 p.m. on 06/24/13, a six inch by two inch rectangular hole in the north wall of Mechanical Room # 5 was not smoke resistant. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned opening in the smoke barrier wall in Mechanical Room # 5 failed to maintain the smoke resistance of</p>	K010025	<ol style="list-style-type: none"> <li>5/8 inch thirty minute smoke resistant drywall was installed on affected area in Mechanical Rm # 5.</li> <li>5 staff or visitors had the potential to be affected by this alleged deficient practice. Drywall was installed on affected area in Mechanical Rm # 5.</li> <li>Maintenance supervisor or designee will be present when new water heaters are installed to ensure any wall damage is appropriately repaired.</li> <li>Mechanical rooms will be inspected monthly for 6 months to ensure smoke barrier walls are intact. Results of audits will be taken to facility monthly CQI meeting for review.</li> <li>Maintenance director is responsible. Completion date 7/9/13</li> </ol>	07/09/2013			

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	the smoke barrier.  3.1-19(b)			

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K010029 SS=E	<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 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 2 doors to hazardous areas such as the kitchen closed automatically or upon activation of the fire alarm system. This deficient practice could affect 25 residents, staff and visitors in the Long Term Care Dining Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 10:45 a.m. to 2:00 p.m. on 06/24/13, the north door in the set of kitchen entry doors from the Main Dining Room was in the fully open position and was not equipped with a self closing or an automatic closing device. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the north door in the set of kitchen entry</p>	K010029	<p>1. A door closer was installed on the north door in the set of kitchen entry doors. b. 5/8 inch thirty minute smoke resistant drywall was installed on affected area in Mechanical Rm # 5.</p> <p>2. 25 residents, staff, and visitors in the long term care dining room had the potential to be affected by this alleged deficient practice. A door closer was installed on the north door in the set of kitchen entry doors. b. 5 staff or visitors had the potential to be affected by this alleged deficient practice. Drywall was installed on affected area in Mechanical Rm # 5.</p> <p>3. A door closer will be installed on any new or repaired doors leading into the kitchen. b. Maintenance supervisor or designee will be present when new water heaters are installed to ensure any wall damage is appropriately repaired.</p>	07/09/2013
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	<p>doors from the Main Dining Room was in the fully open position and was not equipped with a self closing or an automatic closing device.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 5 hazardous areas such as a fuel fired heater rooms was separated from other spaces by smoke resistant partitions and doors. This deficient practice could affect 5 staff or visitors in vicinity of Mechanical Room #5.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 10:45 a.m. to 2:00 p.m. on 06/24/13, a six inch by two inch rectangular hole in the north wall of Mechanical Room # 5 was not smoke resistant. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned opening in the smoke barrier wall in Mechanical Room # 5 failed to separate the area from other spaces by smoke resistant partitions and doors.</p> <p>3.1-19(b)</p>		<p>4. Monthly audit will be conducted for 6 months to ensure all dietary doors equipped with closers are functioning properly. b. Mechanical rooms will be inspected monthly for 6 months to ensure smoke barrier walls are intact. Results of audits will be taken to facility monthly CQI meeting for review</p> <p>5. Maintenance director is responsible. Completion date 7/9/13</p>		

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K010038 SS=E	<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</p> <p>1. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 7 delayed egress locks in the facility was readily accessible for residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the</p>	K010038	<p>1. The delayed egress function on the mag lock by rm 100 exit doors has been repaired and is functioning properly. The set of exit doors by rm 188 have been repaired and are functioning properly.</p> <p>2. 22 residents, staff, and visitors wanting to use the set of exit doors by room 100 and room 188 had the potential to be affected by this alleged deficient practice. The delayed egress function on the mag lock by rm 100 exit doors has been repaired and is functioning properly. The set of exit doors by rm 188 have been repaired and are functioning properly.</p> <p>3. Maintenance director will audit all delayed egress doors and electromagnetically locking doors for proper function thru use of exit door audit.</p> <p>4. Monthly audit will be conducted for 6 months to ensure all delayed egress exit doors are functioning properly. Results of audits will be taken to facility monthly CQI meeting for review.</p> <p>5. Maintenance director is responsible. Completion date 7/9/13</p>	07/09/2013
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	<p>authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. This deficient practice could affect 22 residents, staff and visitors wanting to exit the facility using the set of exit doors by Room 100.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 10:45 a.m. to 2:00 p.m. on 06/24/13, the set of exit doors by Room 100 is equipped with a delayed egress lock and was provided with signage stating the door could be opened in 30 seconds by pushing on the door with the application of force to the release device within 30 seconds but the exit door did not release within 30 seconds when the door was pushed with the application of force five separate times. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the set of exit doors by Room 100 is equipped with a delayed egress lock which was provided with signage stating the door could be opened in 30 seconds by pushing on the door with the application of force to the release device within 30 seconds but the exit door did not release within 30 seconds when the door was pushed with the application of force five separate times.</p>						

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	<p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 10 exit door electromagnetic locks remained unlocked while the fire alarm was activated. LSC 19.2.1 requires every aisle, passageway, corridor, exit discharge, exit location, and access to be in accordance with Chapter 7. LSC 7.2.1.6.2(e) states activation of the building automatic sprinkler or fire detection system, if provided, automatically unlocks the doors and the doors remain unlocked until the fire-protective signaling system has been manually reset. This deficient practice could affect 22 residents, staff and visitors if needing to exit the building near Room 188.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 10:45 a.m. to 2:00 p.m. on 06/24/13, the electromagnetic lock on the set of exit doors by Room 188 did not release and remain unlocked when the fire alarm was activated at 1:32 p.m. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the electromagnetic lock</p>			
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	<p>on the set of exit doors by Room 188 did not release when the fire alarm system was activated.</p> <p>3.1-19(b)</p>			

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K010050 SS=F	<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.</p> <p>Findings include:</p> <p>Based on review of "Monthly Fire Drill Report" documentation with the Maintenance Supervisor during record review from 9:05 a.m. to 10:45 a.m. on 06/24/13, documentation of a fire drill conducted on the first shift for the third quarter of 2012 was not available for review. Based on interview at the time of record review, the Maintenance Supervisor acknowledged documentation of a fire drill conducted on the first shift for the third quarter of 2012 was not available for review.</p> <p>3.1-19(b)</p>	K010050	<ol style="list-style-type: none"> <li>1. Fire drills have been held for all shifts, with appropriate time staggering, since September 2012.</li> <li>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 September 2012.</li> <li>3. A fire drill will be held at unexpected times under varying conditions, at least quarterly on each shift.</li> <li>4. Monthly audit will be conducted for 6 months to ensure fire drill 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.</li> <li>5. Executive director or assistant executive director is responsible. Completion date 7/9/13</li> </ol>	07/09/2013			

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 06/24/2013
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