

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155121	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/06/2013
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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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(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
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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: 06/06/13</p> <p>Facility Number: 000051 Provider Number: 155121 AIM Number: 100275490</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist and Robert Sutton, Life Safety Code Specialist Trainee</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 was consisted 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 was fully sprinklered. The construction was determined to be of</p>	K010000		
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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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	<p>Type III (211) and completed prior to March 1, 2003. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Battery powered smoke detectors protect each resident room. The facility has the capacity for 155 residents 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 by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/11/13.</p> <p>The facility was found not in compliance with the aforementioned requirements as evidenced by:</p>				

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K010018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure doors protecting corridor openings in 2 of 5 first floor smoke compartments could latch into the door frame. This deficient practice affects staff, visitors and 40 or more residents in the north and east first floor smoke compartments which includes the main dining room and physical therapy department.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 06/06/13 between 11:30 a.m. and 3:05 p.m., doors providing access to rooms 214 and 233 failed to latch into their door frames. The maintenance director acknowledged at the</p>	K010018	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No specific residents were found to be affected. The 2 doors identified (rooms 214 and 233) have been modified to allow them to latch into the door frame. Also double door sets identified to the mail room, private dining room, and club room were modified to allow the doors to latch into the door frame. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; All residents utilizing these areas of the campus have the potential to be affected. The 2 doors identified (rooms 214 and 233) have been modified to allow them to latch into the door frame. Also double	07/06/2013			

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	<p>time of observations, the latches were malfunctioning.</p> <p>b. Double door sets to the mail room, private dining room, and one double door set into the club room were each equipped with one door having a manual flush bolt which had to be latched into the door frame before the second door would latch into the first door and secure them both tightly into the door frame. The maintenance director acknowledged at the time of observations, each door could not latch independently into the door frame.</p> <p>3.1-19(b)</p>		<p>door sets identified to the mail room, private dining room and club room were modified to allow the door sets to latch into the door frame. All doors checked to ensure they latch properly What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur; Maintenance director or designee will check all doors in the campus to ensure they latch appropriately weekly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place; Maintenance director or designee will check the identified doors weekly x 4 weeks and then monhly x 6 months to ensure the doors are latching appropriately. The results will be shared with the QA committee for evaluation to ensure the process is working. If not, a new intervention will be determined and intitiated. By what date the systemic changes will be completed;All systemic changes to be completed by 7/6/13</p>		

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K010021 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure a door in 1 of 4 first floor smoke barrier door sets was held open only by a device which would allow it to close upon activation of the fire alarm system. This deficient practice could affect staff, visitors, and 50 or more residents in the first floor south and Auguste's Cottage smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/06/13 at 1:40 p.m., doors in the south smoke barrier double door set on the first floor failed to close when tested twice to ensure proper operation. The doors swung in the same direction and one door hit the second, preventing the doors from closing fully</p>	K010021	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No specific residents were found to have been affected. The double doors have been adjusted to close properly into the door frame. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken; All residents residing in or visiting the areas affected by these doors have the potential to be affected. The double doors have been adjusted to close properly into the door frame. All doors meeting the criteria to automatically close have been checked for proper closure. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does</p>	07/06/2013			

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	into the door frame. The maintenance director acknowledged at the time of observations, the doors were malfunctioning. He said if he timed it "just right", it would not be a problem. 3.1-19(b)		not recur; The maintenance director or designee will check all doors meeting the criteria to automatically close will be checked for proper closure weekly How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; Those doors identified and then adjusted will be checked for proper closure weekly x 4 weeks and then monthly for 6 months. The results will be shared with the QA committee for evaluation to ensure the process is working. If not, a new intervention will be determined and initiated. By what date the systemic changes will be completed; 7/6/13		

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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>Based on observation and interview, the facility failed to ensure doors to 1 of 12 hazardous areas including combustible materials storage rooms larger than 50 square feet self closed to prevent the passage of smoke. This deficient practice could affect visitors, staff and 20 or more residents on the second floor north and west wings.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/06/13 at 1:10 p.m., a door closer was not provided for the door to the new housekeeping storage room on the second floor. The maintenance director acknowledged at the time of observation, the housekeeping storage room with shelving laden with paper products was larger than 50 square feet and had a door which was not self</p>	K010029	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No specific residents were found to have been affected. A self closer has been installed on the door to the new housekeeping storage room. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken; All residents residing in or visiting this area on the second floor have the potential to be affected. Self closers will be installed on all doors meeting the criteria for self closers. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance or designee will check all doors meeting the criteria for self closers to ensure they have been installed and are functioning</p>	07/06/2013			

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	closing. 3.1-19(b)		properly weekly.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; Maintenance or designee will check all doors meeting the criteria for self closers to ensure proper functioning weekly x 4 weeks then monthly x 6 months. The results will be shared with the QA committee for evaluation to ensure the process is working. If not, a new intervention will be determined and initiated. By what date the systemic changes will be completed; 7/6/13		

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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 8 of 10 exit doors equipped with magnetic locks, were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice affects visitors and 60 or more residents.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/06/13 between 11:00 a.m. and 1:50 p.m., emergency exit doors were magnetically locked. The maintenance director demonstrated the locks would release by</p>	K010038	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No specific residents were found to have been affected. The codes to all exit doors requiring a code to exit have been posted with the exception of the Auguste's Cottage housing residents with dementia. The clinical needs of the residents on Auguste's Cottage require specialized security measures for their safety. The east door from Auguste's Cottage has been adjusted and unlocks upon activation of the fire alarm system. The concrete exit discharge surface from Auguste's Cottage emergency exit has been repaired. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected who might utilize these areas. The codes to all exit doors requiring a code to exit have been posted with the exception of the Auguste's Cottage housing residents with dementia. The clinical needs of the residents on Auguste's Cottage require specialized security measures for their safety. The east door from</p>	07/06/2013			

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	<p>entering a code into the keypads located adjacent to each of the doors, however, the code was not posted. The maintenance director said at the time of observations, anyone leaving would have to ask an employee to provide exit access. The maintenance director said at the time of observations, not all residents were considered to have a diagnosis for which locks might be indicated.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 6 locked first floor emergency exits unlocked upon activation of the fire alarm system. LSC 7.2.1.6.2(d) allows buildings protected throughout by an approved supervised automatic fire alarm system to have doors equipped with approved entrance and access control systems which shall automatically unlock upon activation of an approved supervised automatic fire alarm system and shall remain unlocked until the system has been manually reset. This deficient practice affects visitors, staff, and 46 residents on Auguste's Cottage.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/06/13 at 1:45</p>		<p>Auguste's Cottage has been adjusted and unlocks upon activation of the fire alarm system. The concrete exit discharge surface from Auguste's Cottage emergency exit has been repaired. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;The maintenance director or designee will check all doors requiring a code to exit to ensure the code is posted with the exception of the doors in Auguste's Cottage housing residents with dementia weekly. The clinical needs of the residents on Auguste's Cottage require specialized security measures for thier safety. The maintenance director or designee will check all doors meeting the criteria to unlock upon activation of the fire alarm system to ensure they are unlocking properly weekly. The maintenance director or designee will check all exit discharge surfaces from emergency exits to ensure they are in good repair weekly.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;The maintenance director or designee will check all doors requiring a code to exit to ensure the code is posted with the exception of the doors in Auguste' s Cottage housing residents with dementia weekly</p>		

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	<p>p.m., emergency exit doors were equipped with locks designed to unlock upon activation of the fire alarm system. The fire alarm was activated by the maintenance director using a manual pull station, the alarm sounded and doors were checked. The locked east door from Auguste's Cottage remained locked. The maintenance director confirmed, at the time of observations the lock failed to unlock when the fire alarm was activated.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 4 first floor exits were arranged to minimize tripping hazards in accordance with LSC Section 7.1. LSC Section 7.1 requires means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.1.6 requires walking surfaces in the means of egress shall comply with 7.1.6.4. LSC 7.1.6.4 requires walking surfaces to be nominally level. This deficient practice could affect visitors, staff, and 46 residents using the west Auguste's Cottage emergency exits.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director 06/06/13 at 12:30 p.m., the concrete exit discharge surface</p>		<p>x4 then monthly x6. The maintenance director or designee will check all doors meeting the criteria to unlock upon activation of the fire alarm system to ensure they are unlocking properly weekly x 4 then monthly x6. The miantenance director or designee will check all exit discharge surfaces from emergency exits to ensure they are in good repair weekly x 4 then monthly x 6. The results will be shared with the QA committee for evaluation to ensure the process is working. If not, a new intervention will be determined and initiated. By what date the systemic changes will be completed; 7/6/13</p>				

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	<p>for the west Auguste's Cottage emergency exit was damaged where repairs to uneven surfaces were crumbling away. The maintenance director said at the time of observation, the damage had been identified and repairs were planned although no date was set.</p> <p>3.1-19(b)</p>				

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K010046 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation and interview, the facility failed to ensure battery powered emergency lighting fixtures in 2 of 7 smoke compartments would operate. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This deficient practice affects visitors, staff and 21 or more residents in the north smoke compartments of the first and second floors.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/06/13 between 11:30 a.m. and 1:00 p.m., the battery powered emergency lighting failed to illuminate when tested twice in the corridor near the north second floor stairway and in the main entry lobby. The maintenance director acknowledged at the time of observations, the lights were not working.</p>	K010046	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No specific residents were found to have been affected. Batteries were replaced and emergency lighting is now operational. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents in the area where lights failed have the potential to be affected. Batteries replaced in the emergency lights which are now operational. All emergency lights have been checked and illuminate. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director or designee will check all emergency lighting requiring batteries to ensure all are operational weekly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; The maintenance director or designee will check all emergency lighting requiring batteries to ensure they are operational weekly x 4 then monthly x 6 and share results</p>	07/06/2013	

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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			
(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			
K010062 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure a supply of at least two spare sprinkler heads was kept on the premises in a cabinet for each type of sprinkler installed. NFPA 25, 2-4.1.4 requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect any staff or visitor in the mechanical/boiler room and 20 or more residents in the adjacent first floor corridor.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/06/13 at 12:40 p.m., an intermediate rated (green bulb) sprinkler head was installed in the first floor boiler/mechanical room. The spare sprinkler heads were observed with the maintenance director on 06/06/13 at</p>	K010062	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No specific residents were found to have been affected. Intermediate rated sprinkler heads have been obtained to ensure there are a minimum of 2 spare sprinkler heads of each type and temperature in stock on the premises. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected. Intermediate rated sprinkler heads have been obtained to ensure there are a minimum of 2 spare sprinkler heads of each type and temperature in stock on the premises. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director will check the stock of spare sprinkler heads to ensure there are a minimum of 2 spare sprinkler heads of each type and temperature rating weekly. How the corrective action(s) will be monitored to ensure the deficient</p>	07/06/2013			

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	<p>1:10 p.m.. No intermediate rated sprinkler heads were found. The maintenance director said at the time of discovery, he was unaware there were any heads missing.</p> <p>3.1-19(b)</p>		<p>practice will not recur, what quality assurance program will be put into place; The maintenance director or designee will check the stock of sprinkler heads to ensure there are minimum of 2 spare sprinkler heads of each type and temperature rating weekly x 4 then monthly x 6. The results will be shared with the QA committee for evaluation to ensure the process is working, If not, a new intervention will be determined and initiated. By what date the systemic changes will be completed; 7/6/13</p>	

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K010066 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to enforce 3 of 3 of the facility's smoking policies and ensure smoking was limited to designated smoking areas. This deficient practice affects staff, visitors and 20 or more residents on the north side of the east resident sleeping wing.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/06/13 at 1:40 p.m., a smoking area was located outside</p>	K010066	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No specific residents were found to be affected. Staff may smoke in their cars only. No other area is designated for smoking. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected. Staff may smoke in their cars only. No other area is designated for smoking. What	07/06/2013			

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	<p>the south side of the building behind a six foot tall section of fence. The maintenance director identified the area as the designated smoking area for staff and visitors. He said residents were not permitted to smoke. A self closing metal trash can labeled for butt disposal contained paper and plastic wrappers and cigarette butts. An open trash can stored behind the adjacent equipment storage shed contained cigarette butts and dried leaves. A mound of dust, rock and cigarette butts approximately eight to twelve inches tall and a foot in diameter was observed in the center of the smoking area. The ground (floor) was still littered with butts. The perimeter adjacent to the building, near the exit discharges and around the building generator were mulched and littered with a carpet of cigarette butts. Dead leaves had accumulated in the adjacent parking areas at the meeting edges of the curb with an accumulation of cigarette butts. A review of the smoking policy dated 01/10/11 with an effective date of February 1, 2011 stated residents and visitors choosing to smoke would have to do so in a vehicle off the property. The policy further noted "all tobacco smoking devices must be extinguished 50 feet from any entrance and placed in an appropriate receptacle...." An email of 01/10/11 to all employees from the executive director noted as of</p>		<p>measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff have been re-inserviced on the smoking policy and the only designated area for staff smoking; in their cars. The non posted area on the south side of the building is no longer available for smoking and the fence has been removed. The maintenance director or designee will check area around facility for any sign of smoking weekly. How the correctvie action(s) will be monitored to ensure the deficient pracitce will not recur, what quality assurance program will be put into place; Maintenance or designee will check the non posted area on the south side of the building 4x weekly the monthly x 6 to ensure no staff are smoking. All managers are also watching for any evidence of smoking. Results to be shared with QA committee for evaluation to ensure process is working. If not, a new intervention will be determined and initiated. By what date the systemic changes will be completed; 7/6/13</p>		

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	02/1/11 the only designated smoking area for employees would be in vehicles parked in the parking lot. "Employees were to smoke in an automobile in the parking lot." A review of the employee handbook (2012) used for employee orientation had a section, Smoke Free Workplace (pages 39-40) stating smoking is prohibited in the facility and permitted only in designated areas established by the building. It further notes, "Designated areas will be posted with notices and governed by common rules of courtesy and safety." The maintenance director said there may have been an update of the policy but he could find none. He agreed there was nothing in the policies provided to indicate the smoking area used by the equipment supply sheds had been approved and the area was not posted. He further agreed the cigarette butts littering the perimeter of the building in mulch and areas of dead leaves could pose a hazard to residents in rooms adjacent to the mulched areas if they were to ignite. A fire in the grassy bank in front of the building during the past year was mentioned and reinforced the facility staff were aware of the possibility of fire in the much and dried leaves. He agreed the smoking area in use was not mentioned in any documented smoking policy and information provided.						

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	3.1-19(b)				

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K010144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on observation and interview, the facility failed to provide adequate 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, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/06/13 at 1:50 p.m., emergency lighting for the generator set located outside the facility was not provided. Lighting which could have been provided by a vehicle in the parking area was blocked by the growth of shrubs. The maintenance director acknowledged at the time of observation, there was no</p>	K010144	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;No specific residents were found to have been affected by the deficient practice. The shrubs have been removed allowing a vehicle to provide emergency lighting to the generatorHow other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;All residents were identified as having the potential to be affected. The shrubs have been removed allowing a vehicle to provide emergency lighting to the generatorWhat measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director or designee will ensure the generator has emergency lighting by educating our contract lawn care company not to plant any flowers or shrubs in front of the generator and checking weeklyHow the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;The maintenance director or designee</p>	07/06/2013

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	emergency task lighting. 3.1-19(b)		will check generator weekly x 4 and then monthly x 6 to ensure there are no obstacles to getting a vehicle to the generator for emergency lighting. The results will be shared with the QA committee for evaluation to ensure the process is working. If not, a new intervention will be determined and initiated. By what date the systemic changes will be completed; 7-6-13		

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K010147 SS=E	<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 electrical wiring and equipment was in compliance with NFPA 70, National Electrical Code, in 1 of 5 first floor smoke compartments. NFPA 70, 1999 edition, Article 300-11(a) states raceways, cable assemblies, boxes, cabinets and fittings shall be securely fastened in place. This deficient practice could affect staff, visitors and 20 or more residents in the adjacent dining room smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/06/13 at 1:20 p.m., an electrical box connected by conduit to another electrical box hung without support in the dietary food storage room. The maintenance director acknowledged at the time of observation, the box had not been secured correctly and screws holding the box had come loose.</p> <p>3.1-19(b)</p>	K010147	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; No specific residents were found to have been affected. The electrical box has been securely fastened in place. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken; All residents were identified with the potential to be affected. The electrical box has been securely fastened in place. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director or designee will check electrical boxes to ensure they are securely fastened in place weekly. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; The maintenance director or designee will check electrical boxes to ensure they are securely fastened in place weekly x 4 then monthly x 6. The results will be shared with the QA committee for evaluation to ensure the process is working. If not, a new intervention will be determined</p>	07/06/2013			

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			and initiated. By what date the systemic changes will be completed; 7-6-13	

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K010160 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD All existing elevators, having a travel distance of 25 ft. or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.3.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 first floor sprinklered elevator equipment rooms were provided with shunt trip protection. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be of ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon or prior to the application of water from the sprinkler located in the elevator machine room. This deficient practice could affect visitors, staff and 60 or more residents on the first floor.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/06/13 between 11:45 a.m. and 1:45 p.m., the two elevator equipment rooms were equipped with sprinkler coverage, however, shunt trip protection was not</p>	K010160	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No specific residents were found to have been affected. 2 of 2 sprinklered elevator equipment rooms have shunt trip protection installed How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents were identified as having the potential to be affected. 2 of 2 sprinklered elevator equipment rooms have shunt trip protection installed What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; No other areas in the campus meet the criteria for shunt trip valve protection however should that change shunt trip protection will be installed How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;</p>	07/06/2013

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	provided for the sprinklered areas. The maintenance director confirmed at the time of observations, these safety feature were not yet installed. He said there was a plan for installation "this month" but no date was set. 3.1-19(b)		Maintenance direcotr or designee will check the shunt trip valve weekly x 4 then monthly x 6 to ensure operational. Results will be shared with the QA committee for evaluation to ensure the process is working. If not, a new intervention will be determined and initiated. By what date the systemic changes will be completed; 7-6-13		