STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155829	A. BUILDING -- B. WING	08/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRINGS AT LAFAYETTE, THE	2402 SOUTH STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/30/22 Facility Number: 013499 Provider Number: 155829 AIM Number: 201285490 At this Emergency Preparedness survey, The Springs at Lafayette was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 70 certified beds. At the time of the survey, the census was 47. Quality Review completed on 08/31/22	E 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey visit with exit on August 30, 2022.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/30/22 Facility Number: 013499 Provider Number: 155829 AIM Number: 201285490 At this Life Safety Code survey, The Springs at Lafayette was found not in compliance with	K 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance	

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 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 fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, all areas open to the corridors, and all resident rooms with hard wired smoke detectors. The facility has a capacity of 70 and had a census of 47 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 08/31/22		cited during the survey visit with exit on August 30, 2022.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and staff interview, the facility failed to maintain the means of egress free from obstructions in 1 of 8 corridors within the facility. LSC 19.2.3.4(4) states, projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the	K 0211	**Immediate Intervention** The Director of Plant Operations removed the 3 drawer dressers stored in the corridor immediately outside resident rooms #327 and #330 that were not on wheels and relocated to the isolation rooms. The Director of Plant Operations	09/01/2022

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	clear unobstructed corridor width to less than 60 in. (1525 mm.) (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c) The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect approximately 16 residents, 4 staff and 2 visitors. Findings include: Based on observations made with the Director of Plant Operations and the Facility Management Support person on 08/29/22 at 12:30 a.m. during a tour the facility, there were two small 3 drawer dressers stored in the corridor immediately outside resident rooms #327 and #330 that were not on wheels. Based on interview with the Director of Plant Operations at the time of the observation, he acknowledged the items in the corridor were not on wheels and would not allow prompt relocation from the corridor. During the exit conference with the facility Administrator, Facility Management Support person and the Director of Plant Operations at 1:55 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		was educated by the Executive Director on Means of Egress – General. Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2. through 18/19.2.11. 18.2.2, 19.2.1, 7.1.10.1 The Director of Plant Operations will audit each corridor 1 X per day X 30 days followed by 1 X per week X 8 weeks Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect approximately 16 residents, 4 staff and two visitors.	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in			

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	accordance with 7.9. 18.2.9.1, 19.2.9.1 1) Based on observation and interview, the facility failed to ensure 1 of 1 battery powered emergency light at the facility generator was maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observations made with the Director of Plant Operations and the Facility Management Support person on 08/29/22 at 12:10 a.m. during a tour the facility, the facility generator was enclosed within a brick structure. There was no way to light in from the outside so it needed a battery-operated emergency light. Upon opening the panels enclosing the generator, a battery-operated emergency light was located on the back side of a panel within the generator housing. When this light was tested, it failed to light. Based on interview at the time of the observations, both the Director of Plant Operations and the Facility Management Support person stated that they were unaware of the light being there and added that they would add it to the facility testing documents, and have it replaced and working as soon as they would be able to do so. During the exit conference with the	K 0291	**Immediate Intervention** The Director of Plant Operations replaced the battery – operated light and battery that was located on the back side of a panel within the generator housing. The Director of Plant Operations was educated by the Executive Director on Emergency Lighting, Emergency Lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 The Director of Plant Operations will test the operation of the emergency light l**oc**ated in the generator housing 1 X per X 2 Months Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect all residents, staff, and visitors in the facility.	09/09/2022

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	facility Administrator, Facility Management Support person and the Director of Plant Operations at 1:55 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b) 2) Based on observation and interview, the facility failed to ensure 1 of 1 battery backup lights were tested monthly for 30 seconds and annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages, and a written record of visual inspections and tests was provided. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility. Findings include: Based on observations made with the Director of Plant Operations and the Facility Management Support person on 08/29/22 at 12:10 a.m. during a tour the facility, a battery-operated emergency light was located on the back side of a panel within the generator housing. When this light was tested, it failed to light. Based on interview at the time of the observations, both the Director of Plant Operations and the Facility Management			

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	Support person stated that they were unaware of the light being there and added that they would have to add it to the facility testing documents, and have it replaced and working as soon as they would be able to do so. During the exit conference with the facility Administrator, Facility Management Support person and the Director of Plant Operations at 1:55 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)			