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	10/17/2024

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

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/17/24 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 41. Quality Review completed on 10/22/24	E 0000	The submission of this plan of correction does not indicate any admission by The Springs at Lafayette that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of The Springs at Lafayette. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests desk review or substantial compliance.	
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: 10/17/24 Facility Number: 013499 Provider Number: 155829 AIM Number: 201285490	K 0000	The submission of this plan of correction does not indicate any admission by The Springs at Lafayette that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of The Springs at Lafayette. The facility recognizes its obligation to provide legally and	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jeff Weaver	Executive Director	11/08/2024

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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	At this Life Safety Code survey, The Springs at Lafayette was found not in compliance with 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 except for the closet in the Legacy wing by the nurse's station. The facility has a fire alarm system with smoke detection in the corridors, all areas open to the corridors, and in all resident rooms with hard wired smoke detectors. The facility has a capacity of 70 and had a census of 41 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the closet in the Legacy wing by the nurse's station. Quality Review completed on 10/22/24		medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests desk review or substantial compliance.	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Based on record review, observation and interview; the facility failed to document annual testing for all battery backup lights in accordance with LSC 7.9. Section 7.9.3.1.1 states testing of emergency lighting systems shall be permitted to be conducted as follows: (1) 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, except as otherwise permitted by 7.9.3.1.1(2).	K 0291	Immediate Intervention The (DPO) Director of Plant Operations scheduled safe care to perform 90 min emergency light test on E-light located on back panel within the generator housing and two emergency lights in mechanical room. The Director of Plant Operations was educated by the Executive Director on Emergency Lighting, Emergency	11/04/2024

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	(2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the tests required by 7.9.3.1.1(1) and (3). (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, staff and visitors. Findings include: Based on review of "Conduct a 90 minute operational test" documentation dated 02/01/24 with the Executive Director, the Director of Plant Operations (DPO) and the Facilities Management Support during record review from 9:45 a.m. to 1:00 p.m. on 10/17/24, annual 90 minute battery operated light testing documentation for the most recent twelve month period was not itemized by light location. Based on interview at the time of record review, the DPO stated the facility has a total of three battery operated lights in the facility. The DPO stated each battery operated light was additionally functional tested for 90 minutes by an inspection contractor. Review of the inspection contractor's "E-Light Summary Inspection Report" documentation dated 12/01/23 stated "Only 2 emergency lights and 2 exit lights" were tested. Based on interview at the time of record review, the DPO stated the documentation did not show the battery operated light located inside the weather proof shell for the emergency generator was functional tested for at least 90 minutes within the most recent twelve month period.		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 located in the generator housing and two in mechanical room 1 x per x2 months. Results of this audit will be presented by the 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 the facility.	

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	Based on observations with the Executive Director, the Director of Plant Operations (DPO) and the Facilities Management Support during a tour of the facility from 1:40 p.m. to 3:25 p.m. on 10/17/24, three separate battery operated light locations in the facility were noted. Two lights were located inside the Maintenance Office and one light was located inside the weather proof shell for the facility's emergency generator. Each battery operated light illuminated when its respective test button was pushed. These findings were reviewed with the Executive Director, the DPO and the Facilities Management Support during the exit conference. 3.1-19(b)			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 1 of over 18 hazardous areas such as combustible storage rooms/spaces (over 50 square feet) were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Activities Room near the main entrance lobby. Findings include: Based on observations with the Executive Director, the Director of Plant Operations (DPO) and the Facilities Management Support during a tour of the facility from 1:40 p.m. to 3:25 p.m. on 10/17/24, the latching plate on the door frame for the Activities Room storage closet was taped over	K 0321	Immediate Intervention The DPO (Director of Plant Operations) removed the obstruction that wasn't allowing the door to close and latch properly. The (DPO) Director of Plant Operations was educated by the Executive Director on Hazardous Areas- Enclosure hazardous areas are protected by fire barrier having 1-hour fire resistance rating with 3/4-hour fire rated doors or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Activities room near the main entrance.	11/01/2024

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	which did not allow the closet door to latch into the door frame when tested to close. The Activities Room closet measured over 50 square feet and was used to store combustible activities supplies on shelving in the room. The door was equipped with a self closing device. Based on interview at the time of the observations, the DPO agreed taping over the latching plate on the door frame did not separate the closet from other spaces by smoke resistant partitions and doors and removed the tape from the door frame which then allowed the door to self close and latch into the door frame when tested to close. These findings were reviewed with the Executive Director, the DPO and the Facilities Management Support during the exit conference. 3.1-19(b)		The Director of Plant Operations will audit the door located in the Community Room for proper operation of the self-closing device and for proper latching into the frame 1 X per week X 8 weeks. Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to ensure staff had access to a shutoff switch for 1 of 1 cook tops in the Therapy Room. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all of the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all of the	K 0324	Immediate Intervention The DPO (Director of Plant Operations) added a breaker shut-off with timer switch to therapy oven not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action. The DPO (Director of Plant Operations) was educated by the Executive Director and Facility M NFPA 96, 2011 Edition, 19.3.2.5.3(9) states... A switch meeting all of the following is provided:	11/13/2024

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	following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. (c) The switch is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action. This deficient practice could affect over 5 residents, staff and visitors in the Therapy Room. Findings include: Based on observations with the Executive Director, the Director of Plant Operations (DPO) and the Facilities Management Support during a tour of the facility from 1:40 p.m. to 3:25 p.m. on 10/17/24, there was an electric cooktop in the Therapy Room that was separated from the corridor but staff were unable to deactivate the cooktop from electrical power. Based on interview at the time of the observations, the DPO agreed a locked switch on a timer or a switch on a timer located in a restricted location is not provided within the cooking facility that deactivates the cooktop. These findings were reviewed with the Executive Director, the DPO and the Facilities Management Support during the exit conference. 3.1-19(b)		(a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. (c) The switch is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action. This deficient practice could affect over 20 residents, staff and visitors in the Therapy Room. K324 CFR(s) NFPA 101 The DPO (Director of Plant Operations) or designee will audit semiannual inspections 2x every 6 months. Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility	K 0351	Immediate Intervention	11/13/2024

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	failed to ensure a complete automatic sprinkler system was provided for 1 of linen closets by the Legacy wing nurse's station to ensure the facility was protected throughout by an approved automatic sprinkler system. This deficient practice could affect over 10 residents, staff and visitors in the Legacy wing. Findings include: Based on observations with the Executive Director, the Director of Plant Operations (DPO) and the Facilities Management Support during a tour of the facility from 1:40 p.m. to 3:25 p.m. on 10/17/24, the linen closet in the Legacy wing by the nurse's station was not sprinklered. Based on interview at the time of the observations, the DPO agreed the aforementioned linen closet was not sprinklered. These findings were reviewed with the Executive Director, the DPO and the Facilities Management Support during the exit conference. 3.1-19(b)		The (DPO) Director of Plant Operations scheduled sprinkler installation with safe care. Up to 12 residents, 4 staff, and 2 visitors have the potential to be affected by the alleged deficient practice. As a measure of ongoing compliance, the DPO or designee to audit sprinkler heads 2x per month. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review, observation and interview; the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 6.1.2 states Table 6.1.2 shall be used for the inspection, testing, and maintenance of all classes of standpipe and hose systems. Table	K 0353	p paraid="2108224025" paraeid="{c2a771a4-e878-460d-9079-a71131f20f66}{193}" >Immediate Intervention The DPO (Director of Plant Operations) replaced PIV handle, padlock and FDC caps. The Director of Plant operations also scheduled an internal pipe	11/01/2024

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	6.1.2 Standpipe and Hose Systems states where a cap is missing for a Hose Connection it shall be replaced. NFPA 25, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, Section 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the sprinkler system inspection contractor's "KFM Report" documentation dated 03/04/24 with the Executive Director, the Director of Plant Operations (DPO) and the Facilities Management Support during record review from 9:45 a.m. to 1:00 p.m. on 10/17/24, deficiencies were noted for the facility's sprinkler systems. The "Description of Work" section of the 03/04/24 sprinkler system inspection report stated, "PIV handle is missing as well as padlock. Customer asks that both be ordered to replace them. FDC Caps are missing. Pipe is long and deep underground for FDC Connection. Investigation needs to be done to determine if trash is inside pipe along sidewalk". In addition, review of the sprinkler system inspection contractor's "Demand Ticket" documentation dated 06/17/24 indicated "Missing PIV handle (See Photo). Missing FDC Caps and Customer needs quote for FDC internal inspection per Fire Marshall (see Photo)". Based on interview at the time of record review, the DPO		inspection to ensure that there's no trash inside pipe along the sidewalk. The Director of Plant Operations will monitor PIV 2 x per week for 2 months. Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.	

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	stated the facility recently replaced the sprinkler inspection contractor with a different contractor and, as a result, corrections to the PIV and FDC connections were not made on or after 03/04/24. Based on observations with the Executive Director, the DPO and the Facilities Management Support during a tour of the facility from 1:40 p.m. to 3:25 p.m. on 10/17/24, the one PIV for the facility located near the parking lot outside the main entrance on the south side of the property, which was electrically supervised, did not have a handle (wrench) and was not locked. In addition, the two caps for the FDC connection near the city fire hydrant by the sidewalk and city street on the south side of the property were missing. These findings were reviewed with the Executive Director, the DPO and the Facilities Management Support during the exit conference. 3.1-19(b)			