STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155106	A. BUILDING -- B. WING	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVERWALK VILLAGE	295 WESTFIELD RD NOBLESVILLE, IN 46060

(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: 11/21/24 Facility Number: 000044 Provider Number: 155106 AIM Number: 100274940 At this Emergency Preparedness survey, Riverwalk Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 169 certified beds. At the time of the survey, the census was 120. Quality Review completed on 11/25/24	E 0000	By submitting the enclosed Plan of Correction Riverwalk Village is not admitting to the truth or accuracy of any specific finding or allegation. We reserve the right to contest these findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. Please consider this plan of correction as our allegation of compliance. We respectfully request a desk review for this plan of correction.	
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: 11/21/24 Facility Number: 000044 Provider Number: 155106 AIM Number: 100274940 At this Life Safety Code survey, Riverwalk Village was found not in compliance with Requirements	K 0000	By submitting the enclosed Plan of Correction Riverwalk Village is not admitting to the truth or accuracy of any specific finding or allegation. We reserve the right to contest these findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. Please consider this plan of correction as our allegation of compliance. We respectfully request a desk review	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Victoria Roe	Executive Director	12/06/2024

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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	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 was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 169 and had a census of 120 at the time of this survey. All areas where the residents have customary access were sprinklered except for two detached buildings providing facility storage services which were not sprinklered. Quality Review completed on 11/25/24		for this plan of correction.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the means of egress through 1 of 8 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. 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 unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect as many as 25 residents, 4 staff and 2 visitors if needing to exit the courtyard in an emergency such as a fire.	K 0222	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to be affected by this alleged deficient practice. The code is posted at the exit door. How be identified and what	12/18/2024

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	Findings include: Based on observations with the Maintenance Director during a tour of the facility at 12:05 p.m. on 11/21/24, the courtyard door was marked as a facility exit, was magnetically locked and could be opened by entering a four-digit code but the code was not posted at the exit. Based on interview at the time of the observations, the Maintenance Director stated the aforementioned facility exit was indeed marked as exit and could be opened by entering a four-digit code, and agreed the code was not posted. This item was discussed with the Administrator, the Director of Maintenance, and the Maintenance Assistant at the exit conference on 11/21/24. 3.1-19(b)		corrective action(s be taken? All residents residing in this unit had the potential to be affected by this alleged deficient practice. The code was placed on the gate door on 11/21/2024. All other doors were checked to ensure door had the appropriate code visible by the maintenance director. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance director and maintenance assistant were educated on 11/29/2024 on the requirements for egress doors and code postings. Maintenance Director/Designee will check the exit doors to ensure a code is posted. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? POC QAPI Tool (see attached) will be utilized by the maintenance director/designee to monitor all exit doors food code postings weekly for 8 weeks and monthly for 4 months. Any issues will be	

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			corrected immediately and reported to the executive director. All results will be reported to the Quality Assurance and Performance Improvement Committee overseen by the facility Executive Director. If a threshold of 95% is not achieved an action plan will be developed to ensure compliance. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. 12/18/2024	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure the corridor door to 1 of over 8 hazardous areas, such as a House Keeping/Bio-hazard room, a storage room of combustible supplies over 50 square feet in size, was provided with a self-closing device which would cause the door to automatically close and	K 0321	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to be affected by this alleged deficient practice. A device was placed on	12/18/2024

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	latch into the door frame. This deficient practice could affect as many as 14 residents, 4 staff, and 2 visitors within the facility. Findings include: Based on observations made on 11/21/24 at 12:00 p.m. during a tour of the facility with the Maintenance Director and the Maintenance Assistant, the corridor door to the Memory Care spa room did not self-close. This room was approximately 12 feet by 12 feet (144 sq/ft in size) had two 45-gallon containers stored therein, one for trash and the other for dirty linens. The lack of a functioning self-closing device on the memory care spa was acknowledged by the Maintenance Director at the time of the observation stating that he would either move the trash and dirty linen containers or add a self-closing device to the corridor door. This item was discussed with the Administrator, the Director of Maintenance, and the Maintenance Assistant at the exit conference on 11/21/24. 3.1-19(b)		the door. How be identified and what corrective action(s be taken? All residing on this unit had potential to be affected by this alleged deficient practice. A device was placed on the door on 11/21/2024. All doors were checked by maintenance ensure a device was functional for all areas storing hazardous materials. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance director and maintenance assistant were educated on the requirements for Hazardous areas and enclosures. Doors are checked by the maintenance director/designee to ensure mechanisms are functioning for all storing hazardous material. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?	

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			POC QAPI Tool (see attached) will be utilized by the Maintenance director to ensure hazardous areas have required weekly for 8 weeks and monthly for 4 months. Any issues will be corrected immediately and reported to the executive director. All results will be reported to the Quality Assurance and Performance Improvement Committee overseen by the facility Executive Director. If a threshold of 95% is not achieved an action plan will be developed to ensure compliance. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. 12/18/2024	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to provide an approved method for	K 0324	What corrective action(s) will be accomplished for those residents	12/18/2024

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	returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2, states cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 states the fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 states an approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice could affect as many as 12 residents, 8 staff, and 5 visitors in the kitchen and main dining room area. Findings include: Based on observations made on 11/21/24 at 12:47 p.m. during a tour of the facility with the Maintenance Director and the Maintenance Assistant, the six (6) burner flat grill which was located on the cooking line under the hood in the kitchen was not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved for maintenance and cleaning. Based on interview at the time of the observation,		found to have been affected by the deficient practice? No residents were found to be affected by this alleged deficient practice. A wheel caulk was installed for the flat grill. How be identified and what corrective action(s be taken? All residents had the potential to be affected by this alleged deficient practice. The wheel caulks arrived and were installed for the flat grill on 11/21/2024. All other cooking appliances were checked to ensure the proper location by the maintenance director. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance director and maintenance assistant were educated on the approved methods for returning appliances to the approved location for the fire extinguishing How be monitored to ensure the deficient practice will not recur,	

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	the Maintenance Director stated that he was not aware an approved method should be provided to ensure that the appliance was returned to an approved design location after maintenance or cleaning and that he had ordered a "wheel chalk" to remedy the deficiency and would have it installed on the kitchen floor as soon as it arrived. This item was discussed with the Administrator, the Director of Maintenance, and the Maintenance Assistant at the exit conference on 11/21/24. 3.1-19(b)		i.e., what quality assurance program will be put into place? POC QAPI Tool (see attached) will be utilized by the maintenance director to ensure placement and operation the wheel caulks weekly for 8 weeks and monthly for 4 months. Any issues will be corrected immediately and reported to the executive director. All results will be reported to the Quality Assurance and Performance Improvement Committee overseen by the facility Executive Director. If a threshold of 95% is not achieved an action plan will be developed to ensure compliance. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. 12/18/2024	

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K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation, and interview; the facility failed to ensure 9 of over 100 sprinklers were replaced or cleaned in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect two staff in the laundry room. Findings include: Based on observations made on 11/21/24 between 11:50 a.m. and 2:00 p.m. during a tour of the facility with the Maintenance Director and the Maintenance Assistant, the following was noted: a) 5 of 5 sprinkler heads outside under the facilities main entrance overhang were dirty and over 50 years old and needed to be replaced per	K 0353	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to be affected by this alleged deficient practice. The dirty and old sprinkler heads have been replaced in the entrance overhang and in the laundry room. How be identified and what corrective action(s be taken? All residents had the potential to be affected by this alleged deficient practice. The sprinkler heads have all will on or before 12/18/24. All other sprinkler heads were checked to ensure proper working order by the maintenance director. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance director and maintenance assistant were educated on the requirements for sprinkler head appearance and requirements for cleaning or replacement. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? POC QAPI Tool (see attached) will be utilized by the maintenance director to ensure all sprinkler heads are clean and in good repair weekly for 8 weeks	12/18/2024

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	the Integrated Electronics Inc. (I.E.I.) sprinkler inspection dated 08/12/24. b) 4 of 4 sprinkler heads located in the laundry room on the "dirty side" were dirty and over 50 years old and needed to be replaced per the Integrated Electronics Inc. sprinkler inspection dated 08/12/24. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned sprinkler heads were dirty and out of date adding that they have been ordered but were on back-order and that he would have I.E.I. install them as soon as they arrived. This item was discussed with the Administrator, the Director of Maintenance, and the Maintenance Assistant at the exit conference on 11/21/24. 3.1-19(b)		and monthly for 4 months. Any issues will be corrected immediately and reported to the executive director. All results will be reported to the Quality Assurance and Performance Improvement Committee overseen by the facility Executive Director. If a threshold of 95% is not achieved an action plan will be developed to ensure compliance. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. 12/18/2024	