STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING -- B. WING	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEWALK VILLAGE	1302 N LESLEY AVE INDIANAPOLIS, IN 46219

(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: 03/31/25 Facility Number: 000222 Provider Number: 155329 AIM Number: 100274950 At this Emergency Preparedness survey, Rosewalk Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 161 certified beds. At the time of the survey, the census was 99. Quality Review completed on 04/04/25	E 0000	**The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents. The Facility formally requests a desk review of the following plans 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: 03/31/25 Facility Number: 000222 Provider Number: 155329 AIM Number: 100274950 At this Life Safety Code survey, Rosewalk Village was found not in compliance with Requirements	K 0000	**The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents. The Facility formally requests a desk review of the following plans of correction.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Omar K Johnson	Executive Director	04/21/2025

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	155329	A. BUILDING 01 B. WING	03/31/2025

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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 (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 detectors are installed in resident sleeping rooms. Smoke detectors hard wired to the fire alarm system are additionally installed in resident sleeping rooms 201 through 211. The facility has a capacity of 161 and had a census of 99 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except two detached wooden sheds providing facility storage. Quality Review completed on 04/04/25			
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed ensure 1 of 1 kitchen hood extinguishing system provide complete coverage for equipment that produces grease-laden vapors. NFPA 96, 2011 edition, Section 10.1.2 requires cooking equipment that produces grease-laden vapors and that might be a source of ignition of grease in the hood, grease removal device, or duct shall be protected by fire-extinguishing equipment. Section 11.1.6 states cooking equipment shall not be operated while its fire-extinguishing system or exhaust system is nonoperational or impaired.	K 0324	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The six-burner stove to be protected by fire suppression system. Corrected on 4/15/2025. **How will you identify other residents having the potential**	04/15/2025

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	This deficient practice could affect 30 residents, staff in visitors in one smoke compartment. Findings include: Based on observation during a tour of the facility with the Field Maintenance Supervisor and Maintenance Director on 03/31/25 at 2:35 p.m., the six burner stove was not completely covered by the fire suppression system. The nozzles were angled up towards a stainless steel shelf above the burners. Based on interview at the time of observation, the Field Maintenance Supervisor agreed the lack of fire suppression for the aforementioned cooking equipment and stated the vendor for the suppression system would be contacted to reorient the nozzles. This finding was reviewed with the Executive Director, Field Maintenance Supervisor and Maintenance Director at the exit conference. 3.1-19(b)		**to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Annual inspection of fire suppression system to be conducted and logged. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** —— The ED/designee will be responsible for monitoring the quarterly hood inspection to include fire suppression system. —— Results of inspection to be placed in binder and shared at QA meeting during that time frame of inspection. **How will the corrective action (s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·To ensure compliance the ED/designee will complete a fire suppression system audit POC CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a ED or designee. The fire suppression system audit POC CQI audit tool	

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			will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee. **By What date will the systematic changes be completed** Compliance date April 15, 2025	
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Based on observation and interview, the facility failed to ensure 1 of 60 resident room corridor doors was maintained in accordance with 18.7.5.6. 18.7.5.6 states combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met: (1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is applied. (2) The decorations meet the requirements of NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. (3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW ignition source. (4)*The decorations, such as photographs,	K 0753	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The corridor door to resident room 119 has been cleared from decoration. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. An audit will be completed by ED/designee by 4/18/2025 of all	04/11/2025

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	paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in accordance with the following: (a) Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations of 18.7.5.6(b), (c), or (d). (b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7. (c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7. (d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. This deficient practice could affect 15 residents, staff and visitors in one smoke compartment. Findings include: Based on observation with the Maintenance Director during a tour of the facility at 2:05 p.m. on 03/31/25, the corridor door to resident room 119 was covered over 30 percent with decorative holiday material. Based on interview with the Maintenance Director at 2:06 p.m., he stated the decorations were not treated with fire retardant material as far as he knew and agreed the surface of the door was covered more than 30 percent. This finding was reviewed with the Executive		residents doors to ensure doors are free of combustible decorations that do not meet allowable criteria. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** An in-service will be completed by ED/designee with maintenance staff by 4/18/2025 on the guideline's concerning combustible decorations. ED/Designee will round weekly to ensure doors are in compliance. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·To ensure compliance the ED/Designee will complete door POC CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by ED or designee. The POC CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not	

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	Director, Field Maintenance Supervisor and Maintenance Director, during the exit conference. 3.1-19(b)		achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of the employee responsible. **By What date will the systematic changes be completed** Compliance date 4/11/2025	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on record review, observation, and interview, the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is	K 0921	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Thefacility must ensure that all PCREE are tested. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. DNS/Designee to conduct an audit/test on all PCREE building wide. **What measures will be put into place or what systemic changes you will make to**	04/17/2025

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	maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice could affect all residents. Findings include: Based on record review on 03/31/25 at 12:46 p.m. with the Maintenance Director and Field Maintenance Supervisor present, there was no documentation for the testing of Patient Care Related Electrical Equipment (PCREE), such as electric beds, nebulizers, oxygen concentrators, air pumps for air mattresses, and other electrical medical equipment. Based on interview at 12:48 p.m., the Field Maintenance Supervisor said the facility has not yet tested and documented the PCREE items, and he is due to be trained on the requirement. Based on observations between 12:50 p.m. and 3:05 p.m. during a tour of the facility with the Maintenance Director and Field Maintenance Supervisor, it was revealed the facility provided PCREE such as electric beds, air pumps for air mattresses, and other electrical medical equipment was present in the facility. This finding was reviewed with the Executive Director, Maintenance Director, and Field Maintenance Supervisor during the exit conference. 3.1-19(b)		**ensure that the deficient practice does not recur?** ·ED/Designee will keep audits of all items tested ·ED/Designee will round on any new PCREE to ensure integrity of wiring. **How will the corrective action (s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ED/Designee will be responsible for monitoring/auditing the POC QAPI tool completed Weekly times 4 weeks, monthly times 5 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If a threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. **By What date will the systematic changes be completed** Compliance date 4/17/2025	