CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u></u>	COMPLETED	
		155329	B. WING		02/22/2024	
	PROVIDER OR SUPPLIER	<u>. </u>	STREET 1302 N INDIAN			
(X4) ID	SHMMARV	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	i i	
TAG	,	R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
E 0000	REGUENTORT OF	LESC IDENTIFICATION OR MATTER	1710		DATE	
L 0000						
Bldg	conducted by the In accordance with 42 Survey Date: 02/22 Facility Number: 0 Provider Number: 100 At this Emergency Rosewalk Village v Emergency Prepare Medicare and Mediand Suppliers, 42 C The facility has 161 the survey, the cens	2/24 200222 155329 274950 Preparedness survey, vas found in compliance with edness Requirements for caid Participating Providers 2FR 483.73.	E 0000	The Facility offers its respondence allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents. The Facility formally request desk review of the following plans of correction.	ts a	
K 0000						
•						
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 02/22 Facility Number: 0 Provider Number: AIM Number: 100	00222 155329	K 0000	The Facility offers its respondence of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents. The Facility formally request desk review of the following plans of correction.	ts a	
	was found not in co	ompliance with Requirements				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Omar Khayyam Johnson Executive Director 03/11/2024

Any defiency statement 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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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155329	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE S COMPLE 02/22/2	ETED
	PROVIDER OR SUPPLIER		1302 N	ADDRESS, CITY, STATE, ZIP COD LESLEY AVE JAPOLIS, IN 46219		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	E RIATE	(X5) COMPLETION DATE
	Subpart 483.90(a), 1 2012 edition of the Association (NFPA Chapter 19, Existing 410 IAC 16.2. This one story facility Type V (000) const. The facility has a find detection in the corridor. Batter are installed in resid detectors hard wired additionally installe 201 through 211. The and had a census of All areas where residence sprinklered. Asservices were sprinklered.	Medicare/Medicaid, 42 CFR Life Safety from Fire and the National Fire Protection) 101, Life Safety Code (LSC), g Health Care Occupancies and ity was determined to be of ruction and fully sprinklered. re alarm system with smoke ridors and in all areas open to y operated smoke detectors lent sleeping rooms. Smoke it to the fire alarm system are d in resident sleeping rooms the facility has a capacity of 161 104 at the time of this visit. dents have customary access all areas providing facility clered except two detached iding facility storage.				
K 0100 SS=C Bldg. 01	Section 18.1 and that are not address. K-tags, but are de along with the app NFPA standard cit on Form CMS-256. Based on observation failed to remove 1 calarm remote annual readily observed by	nents - Other RKS section any LSC 19.1 General Requirements ssed by the provided ficient. This information, slicable Life Safety Code or tation, should be included	K 0100	What corrective action(s) w be accomplished for those residents found to have be affected by the deficient practice?		03/08/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPLETED	
		155329	B. W	ING		02/22/2024	
),,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	NOTHER OF STATE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	t	1302 N LESLEY AVE				
ROSEWA	ALK VILLAGE			INDIAN	IAPOLIS, IN 46219		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		ic if not required by the Code,			·Facility to remove the esse	ntial	
		tained or removed. This			electric system alarm remote		
	deficient practice could affect all residents, staff				annunciator.		
	and visitors.						
					How will you identify other		
	Findings include:				residents having the potentia	al	
	December 1	ial al - M-i-a			to be affected by the same		
		ons with the Maintenance			deficient practice and what	2	
	Director and the Field Maintenance Supervisor				corrective action will be take		
	during a tour of the facility from 11:45 a.m. to 2:05 p.m. on 02/22/24, one of the two remote				·All residents have the poter to be affected by the alleged	iliai	
	_	located at the south nurse's			deficient practice.		
	_	ty's emergency generator had			·Annunciator was removed I	nv.	
		and failed to illuminate its			Maintenance Director on	Oy	
	_	n its test button was depressed			2/22/2024.		
		e inoperable annunciator panel			2/22/2024.		
	_	a yellow colored shell. The			What measures will be put ir	nto	
		inciator panel for the			place or what systemic		
		or at the south nurse's station			changes you will make to		
		r and the warning lights for the			ensure that the deficient		
	_	when its test button was			practice does not recur?		
	1 ~	operable remote annunciator			·An in-service will be comple	eted	
	_	n the corridor wall at the north			by ED/Designee with mainten		
	1 ~	neplate information affixed to			personnel to ensure complian		
	the emergency gene	erator located outside the			with the requirements of this		
	facility on the west	side of the property indicated			deficiency.		
	the unit was rated a						
		bruary 2014. Based on			How the corrective action (s))	
		e of the observations, the			will be monitored to ensure t	the	
		or and the Field Maintenance			deficient practice will not		
		e facility has one diesel fired			recur, i.e., what quality		
		or, the facility has two operable			assurance program will be p	ut	
		panels and agreed the yellow			into place?		
		unciator at the south nurse's			·The ED is responsible for		
		rical power and should be			ensuring the proper number o		
	removed.				annunciators are located withi	n	
					the facility.		
	_	e reviewed with the Executive			·The ED/designee will be		
		enance Director and the Field			responsible for monitoring or		
	Maintenance Super	visor during the exit			auditing the installation of futu	re	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155329	B. W	NG		02/22/2024	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					LESLEY AVE		
ROSEWA	ALK VILLAGE			INDIAN	IAPOLIS, IN 46219		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWIDERIC DI ANI OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE
	conference.				annunciator as needed per		
					replacement as required. The	;	
	3.1-19(b)				results of these audits will be		
	,				reviewed by the QAPI commit	tee	
					overseen by the ED. If thresho		
					100% is not achieved, an action		
					plan will be developed. Deficie		
					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 3/8/2024		
					K 222 egress Doors- Code or	า	
					door Memory Care		
					What corrective action(s) wil	I	
					be accomplished for those		
					residents found to have been	ı	
					affected by the deficient		
					practice?		
					·Facility door located on the		
					memory care unit to have cod	e on	
					keypad for entry and exit.		
					How will you identify other		
					residents having the potentia	al	
					to be affected by the same		
					deficient practice and what		
					corrective action will be take	n?	
					·All residents have the poter	ntial	
					to be affected by the alleged		
					deficient practice.		
					·Code to door was applied fo	or	
					both exit and entrance on		
					2/22/2024.		

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What measures will be put into

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155329	ì í	LDING	onstruction 01	(X3) DATE SURVEY COMPLETED 02/22/2024	
NAME OF P	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD		
ROSEWA	ALK VILLAGE		1302 N LESLEY AVE INDIANAPOLIS, IN 46219				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	ì ·	CY MUST BE PRECEDED BY FULL	P	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	place or what systemic	DATE	_
					changes you will make to		
					ensure that the deficient		
					practice does not recur?		
					·An in-service will be compl	eted	
					by ED/Designee with mainten		
					personnel to ensure complian	ice	
					for all required posting.	,	
					How the corrective action (s will be monitored to ensure	, I	
					deficient practice will not	tne	
					recur, i.e., what quality		
					assurance program will be p	out	
					into place?		
					Maintenance/ED will comp	lete	
					a POC CQI audit tool for six		
					months with audits being		
					completed once weekly for or		
					month, and then monthly for 6	6	
					months by		
					Maintenance/Designee. The F		
					CQI audit tool will be reviewed monthly by the CQI committed		
					six months after which the CC		
					team will re-evaluate the cont		
					need for the audit. If a 95%		
					threshold is not achieved an a	action	
					plan will be developed. of the	•	
					responsible employee, the res		
					of these audits will be reviewe	-	
					the QAPI committee overseer	•	
					the ED. If a threshold of 100%		
					not achieved, an action plan v	VIII	
					be developed.		
					·By What date will the		
					systematic changes be		
					completed?		
					·Compliance date 3/8/2024		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155329	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	COM	TE SURVEY IPLETED 22/2024
	PROVIDER OR SUPPLIER ALK VILLAGE		1302 N	ADDRESS, CITY, STATE, ZIP (LESLEY AVE APOLIS, IN 46219	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
TAG K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a require be equipped with a requires the use o egress side unless special locking arr CLINICAL NEEDS LOCKING Where special lock clinical security ne used, only one loc permitted on each be made for the ra by: remote control locks or keys carri other such reliable staff at all times. 18.2.2.2.5.1, 18.2. 19.2.2.2.6 SPECIAL NEEDS ARRANGEMENTS Where special lock safety needs of the the Clinical or Sec are being met. In a electrical locks tha release upon loss building is protecte automatic sprinkle space is protected detection system (at an attended loc space); and both t	king arrangements for the leds of the patient are king device shall be door and provisions shall apid removal of occupants of locks; keying of all led by staff at all times; or a means available to the 2.2.6, 19.2.2.2.5.1, LOCKING Sking arrangements for the leap patient are used, all of surity Locking requirements addition, the locks must be leaf tail safely so as to of power to the device; the led by a supervised or system and the locked led by a complete smoke for is constantly monitored lation within the locked he sprinkler and detection ged to unlock the doors 2.2.5.2, TIA 12-4 SS LOCKING	TAG			DATE
				l		1

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i i		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED				
		155329	B. WING		02/22/2024		
			STREI	ET ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIER	2		N LESLEY AVE			
ROSEWA	ALK VILLAGE		INDIANAPOLIS, IN 46219				
	1		<u>, l</u>				
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENC!)	DATE		
		lelayed-egress locking					
	_	in accordance with					
	7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire						
	detection system or an approved, supervised automatic sprinkler system.						
	18.2.2.2.4, 19.2.2.	•					
	ACCESS-CONTR						
	LOCKING ARRAN						
	Access-Controlled Egress Door assemblies						
	installed in accordance with 7.2.1.6.2 shall						
	be permitted.						
	18.2.2.2.4, 19.2.2.	.2.4					
	ELEVATOR LOBE	BY EXIT ACCESS					
	LOCKING ARRAN	NGEMENTS					
		t access door locking in					
		'.2.1.6.3 shall be permitted					
		es in buildings protected					
		approved, supervised					
		ection system and an					
		sed automatic sprinkler					
	system.	0.4					
	18.2.2.2.4, 19.2.2.		17 0000	What same stirred is	02/00/2024		
		on and interview, the facility means of egress through 2 of	K 0222	What corrective action(s) wi	03/08/2024		
		y accessible for residents		be accomplished for those residents found to have bee	ın e		
		iagnosis requiring specialized		affected by the deficient	·n		
		Doors within a required means		practice?			
		be equipped with a latch or		·Facility door located on the	_		
	_	he use of a tool or key from the		memory care unit to have coo			
	_	therwise permitted by LSC		keypad for entry and exit.			
	-	ction 7.2.1.5.3 states locks, if		How will you identify other			
		require the use of a key, a tool,		residents having the potent	ial		
	_	ge or effort for operation from		to be affected by the same			
		or-locking arrangements shall		deficient practice and what			
	be permitted in acco	ordance with 19.2.2.2.5.2. This		corrective action will be take	en?		
	deficient practice co	ould affect over 20 residents,		·All residents have the pote	ntial		
	staff and visitors.			to be affected by the alleged			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155329	B. WI	NG		02/22/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIEF	₹			LESLEY AVE		
ROSEW/	ALK VILLAGE				APOLIS, IN 46219		
TOOL VV	LIX VILLAGE			וואטואויי	7.11 OLIO, 114 TOZ 18		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	CROSS-REFERENCED TO THE AP		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					deficient practice.		
	Findings include:				·Code to door was applied fo	or	
					both exit and entrance on		
		ons with the Maintenance			2/22/2024.		
	Director and the Field Maintenance Supervisor				What measures will be put ir	nto	
	during a tour of the facility from 11:45 a.m. to 2:05				place or what systemic		
	_	he corridor door set at the			changes you will make to		
	_	e's Cottage was marked as a			ensure that the deficient		
	-	exit sign and was equipped			practice does not recur?		
	with magnetic locking devices to keep the doors				·An in-service will be comple		
		or set was in the fully closed			by ED/Designee with mainten		
	*	set could be released to open			personnel to ensure complian	ce	
		at a keypad, but the code was			for all required posting.		
	_	ypad. The corridor door set at			How the corrective action (s))	
	_	he outside of the facility by			will be monitored to ensure t	the	
		marked as a facility exit and			deficient practice will not		
		with magnetic locking devices			recur, i.e., what quality		
		vas in the fully closed position.			assurance program will be p	ut	
		be released to open by			into place?		
		he keypad, but the code was			·Maintenance/ED will compl	ete	
	_	on interview at the time of the			a POC CQI audit tool for six		
	·	laintenance Director and the			months with audits being		
		Supervisor agreed the code to			completed once weekly for on		
		s to open was not posted at			month, and then monthly for 6	i	
	the door sets but sh	ould be.			months by		
					Maintenance/Designee. The F		
	_	e reviewed with the Executive			CQI audit tool will be reviewed		
	*	enance Director and the Field			monthly by the CQI committee		
	-	visor during the exit			six months after which the CQ		
	conference.				team will re-evaluate the conti	nued	
	2.4.40.43				need for the audit. If a 95%		
	3.1-19(b)				threshold is not achieved an a		
					plan will be developed. of the		
					responsible employee, the res		
					of these audits will be reviewe	-	
					the QAPI committee overseen	-	
					the ED. If a threshold of 100%		
					not achieved, an action plan w	vill	
					be developed.		
			1				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155329	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 02/22/2024
	PROVIDER OR SUPPLIER		1302 N	ADDRESS, CITY, STATE, ZIP COD N LESLEY AVE NAPOLIS, IN 46219	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	COMPLETION
				·By What date will the systematic changes be completed? ·Compliance date 3/8/202	4
K 0321 SS=E Bldg. 01	barrier having 1-hi (with 3/4 hour fire automatic fire extinaccordance with 8 approved automation option is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-ado not exceed 48 the door. Describe the floor hazardous areas to REMARKS. 19.3.2.1, 19.3.5.9 Area Separation a. Boiler and Fuel-b. Laundries (large c. Repair, Maintend. Soiled Linen Rogallons) e. Trash Collection (exceeding 64 gal f. Combustible Sto (over 50 square fee	are protected by a fire pur fire resistance rating rated doors) or an anguishing system in 1.7.1 or 19.3.5.9. When the ic fire extinguishing system areas shall be separated by smoke resisting rs in accordance with 8.4. If closing or and permitted to have applied protective plates that inches from the bottom of and zone locations of that are deficient in Automatic Sprinkler N/A Fired Heater Rooms er than 100 square feet) ance, and Paint Shops from soms (exceeding 64 and Rooms) orage Rooms/Spaces set) classified as Severe			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 02/22/2024 155329 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1302 N LESLEY AVE INDIANAPOLIS, IN 46219 **ROSEWALK VILLAGE** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Based on observation and interview, the facility K 0321 What corrective action(s) will 03/08/2024 failed to ensure 3 of over 20 hazardous areas such be accomplished for those as combustible storage rooms/spaces (over 50 residents found to have been square feet), soiled linen and trash collection affected by the deficient rooms and boiler and fuel-fired heater rooms were practice? separated from other spaces by smoke resistant ·Facility to have all hazardous partitions and doors. Doors shall be self-closing items behind doors with a or automatic closing in accordance with 7.2.1.8. self-closing device. This deficient practice could affect over 20 ·Door 141 is affixed with a residents, staff and visitors. self-closing device. ·Door 175 is affixed with a Findings include: self-closing device. The pipe that penetrated the Based on observations with the Maintenance ceiling is sealed with firestopped Director and the Field Maintenance Supervisor during a tour of the facility from 11:45 a.m. to 2:05 How will you identify other p.m. on 02/22/24, the corridor door to the Laundry residents having the potential Services room by Room 141 was equipped with a to be affected by the same self-closing device but the door failed to fully deficient practice and what self-close and latch into the door frame when corrective action will be taken? tested to close multiple times. One 20-gallon ·All residents have the potential capacity and one 32-gallon capacity soiled linen to be affected by the alleged carts were stored in the room. In addition, deficient practice. resident sleeping Room 175 was converted to a ·All doors were inspected by storage and supply room for combustible boxes maintenance director/designee to and supplies. The corridor door to the room was ensure the self-closing device was not equipped with a self-closing device. The operational for storage annular space surrounding a two inch in diameter room/spaces. natural gas pipe which penetrated the ceiling of What measures will be put into the natural gas fired water heater room across place or what systematic from the north nurse's station was not changes you will make to firestopped. Based on interview at the time of the ensure that the deficient observations, the Maintenance Director and the practice does not recur? Field Maintenance Supervisor agreed the ·An in-service will be completed aforementioned three hazardous areas were not by ED/Designee with maintenance separated from other spaces with smoke resistant personnel to ensure compliance partitions and doors. for all doors requiring self-locking devices. These findings were reviewed with the Executive Director, the Maintenance Director and the Field How the corrective action (s)

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	OF CORRECTION	IDENTIFICATION NUMBER 155329	A. BUILDING B. WING	01	COMPLETED 02/22/2024
	ROVIDER OR SUPPLIER		1302 N	ADDRESS, CITY, STATE, ZIP COD LESLEY AVE JAPOLIS, IN 46219	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Maintenance Superviconference. 3.1-19(b)	visor during the exit		will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place? ·Maintenance/ED will compa POC CQI audit tool for six months with audits being completed once weekly for or month, and then monthly for emonths by Maintenance/Designee. The CQI audit tool will be reviewe monthly by the CQI committe six months after which the CQI team will re-evaluate the contineed for the audit. If a 95% threshold is not achieved an aplan will be developed. By What date will the systematic changes be completed? ·Compliance date 3/8/2024	POC d e for QI cinued
K 0351 SS=E Bldg. 01	by construction type throughout by an a sprinkler system in 13, Standard for the Systems. In Type I and II conprotection measure substituted for sprinklers.	Installation nd hospitals where required			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u>	COMPLETED	
		155329	B. W	NG		02/22	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			LESLEY AVE		
ROSEWA	ALK VILLAGE				IAPOLIS, IN 46219		
1100EVV	· · · · · · · · · · · · · · · · · · ·			IIVDIAIV	, 4 0210, 114 40210		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	CROSS-REFERENCED TO THE APPROP		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΙΤΕ	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	sprinklers.						
		klers are not required in					
		patient sleeping rooms					
		the closet does not exceed					
	•	sprinkler coverage covers					
	the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) 1. Based on observation and interview, the facility						
			17.0	251	NAME - 4		02/09/2024
		_	K 0	331	What corrective action(s) will		03/08/2024
	failed to ensure the spray pattern for sprinkler heads were not obstructed in 1 of 2 storage rooms				be accomplished for those residents found to have been	_	
		room in accordance with LSC				11	
		, 2010 edition, Section 8.5.5.1			affected by the deficient		
		all be located so as to minimize			practice? •For the spray pattern for		
	_	harge as defined in Section			sprinkler head to not be		
		8.5.5.3 or additional sprinklers			obstructed.		
		ensure adequate coverage of			obstructeu.		
	-	s 8.5.5.2 and 8.5.5.3 do not			How will you identify other		
		or noncontinuous obstructions			residents having the potentia	al	
	_	o 18 inches below the sprinkler			to be affected by the same		
	_	rizontal plane more than 18			deficient practice and what		
		orinkler deflector that prevent			corrective action will be take	n?	
	•	om fully developing. This			·All residents have the poter		1
		ould affect over 10 residents,			to be affected by the alleged		
	_	the vicinity of the main dining			deficient practice.		
	room.				Boxes were removed from	the	
					storage room area.		1
	Findings include:						
					What measures will be put ir	ıto	
	Based on observation	ons with the Maintenance			place or what systemic		
	Director and the Fig	eld Maintenance Supervisor			changes you will make to		
		facility from 11:45 a.m. to 2:05			ensure that the deficient		
	_	ardboard boxes were stacked			practice does not recur?		
		e ceiling in the Dietary Storage			·An in-service will be comple		
		ining room which obstructed			by ED/Designee with mainten		
		r the one sprinkler in the room.			personnel to ensure complian		
	Based on interview				with all mandatory requiremer	nts	
	observations, the M	laintenance Director and the			for the Sprinkler System.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMPL		COMPLE	ETED
		155329	B. W			02/22/2	
					_		-
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
					LESLEY AVE		
ROSEW	ALK VILLAGE			INDIAN	IAPOLIS, IN 46219		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE N. AM OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NE	DATE
		Supervisor agreed the stacked					
		would obstruct the sprinkler			How the corrective action (s)	,	
	spray pattern.				will be monitored to ensure t		
					deficient practice will not		
	These findings wer	e reviewed with the Executive			recur, i.e., what quality		
	_	enance Director and the Field			assurance program will be p	ut	
	Maintenance Supervisor during the exit				into place?		
	conference.				·Maintenance/ED will compl	_{ete}	
					a POC CQI audit tool for six		
	3.1-19(b)				months with audits being		
					completed once weekly for on	e	
	2. Based on observation and interview, the facility				month, and then monthly for 6		
	failed to maintain the ceiling construction in 1 of 1				months by		
	restrooms in Auguste's Cottage dining room in				Maintenance/Designee. The F	oc l	
	accordance with NFPA 13, Standard for the				CQI audit tool will be reviewed		
		nkler Systems. NFPA 13, 2010			monthly by the CQI committee		
	_	2.7.1 states plates, escutcheons,			six months after which the CQ		
		ed to cover the annular space			team will re-evaluate the conti		
		shall be metallic or shall be			need for the audit. If a 95%		
	-	d a sprinkler. This deficient			threshold is not achieved an a	ction	
	practice could affect	et over 10 residents, staff and			plan will be developed		
	visitors in the vicin	ity of Auguste's Cottage					
	dining room.				By What date will the		
					systematic changes be		
	Findings include:				completed?		
					·Compliance date 3/8/2024		
	Based on observation	ons with the Maintenance					
	Director and the Fi	eld Maintenance Supervisor					
	during a tour of the	facility from 11:45 a.m. to 2:05					
	p.m. on 02/22/24, o	one of one ceiling mounted					
	sprinkler locations	in the restroom in the					
	Auguste's Cottage	dining room had a missing					
		on interview at the time of the					
	observations, the M	faintenance Director and the					
		Supervisor agreed the					
	aforementioned spr	rinkler location was missing its					
	escutcheon.						
	These findings wer	e reviewed with the Executive					
		enance Director and the Field					

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155329		A. BUILDING <u>01</u> COMPLETEI B. WING 02/22/202					
				02/22/	2024		
	ROVIDER OR SUPPLIER ALK VILLAGE			1302 N	ADDRESS, CITY, STATE, ZIP COD LESLEY AVE APOLIS, IN 46219		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		DROWING BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	conference.	visor during the exit					
K 0353 SS=E Bldg. 01	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Maintenance Supervisor during the exit		K 0.	353	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Replacement of new sprinkl How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be taken All residents have the potentian action.	n ler. al	03/11/2024

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDEN		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
		155329	B. WING 02/22/2024				
		1		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8			LESLEY AVE		
ROSEW/	ALK VILLAGE				IAPOLIS, IN 46219		
	Т				T	Т	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		PLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			ATE
	(2) Corrosion				to be affected by the alleged		
	(3) Physical Damag				deficient practice.		
	1 ' '	the glass bulb heat responsive			The sprinkler system is a d	У	
	element				system. Measurements of old		
	(5) Loading				sprinkler head conducted on		
		painted by the sprinkler			3/11/2024 for replacement on		
	manufacturer.				same day.		
		sprinklers that are loaded with			·All sprinkler heads were		
		to clean sprinklers with			inspected by maintenance	. [
		y a vacuum provided that the			director/designee to ensure al		
		touch the sprinkler.			were free from paint.		
		ice could affect over 10					
		visitors in the vicinity of the			What measures will be put in	ito	
	storage room by Ro	oom 106.			place or what systemic		
					changes you will make to		
	Findings include:				ensure that the deficient		
					practice does not recur?		
		ons with the Maintenance			·An in-service will be comple		
		eld Maintenance Supervisor			by ED/Designee with mainten		
	_	facility from 11:45 a.m. to 2:05			personnel to ensure complian	ce	
	1 ~	he deflector for the sprinkler			with all mandatory sprinkler		
	1	ge room by Room 106 was			system requirements.		
	_	interview at the time of the			How the corrective action (s		
	l '	Iaintenance Director and the			will be monitored to ensure	he	
		Supervisor agreed the			deficient practice will not		
		omatic sprinkler location had			recur, i.e., what quality	_	
	paint on the deflect	or.			assurance program will be p	ut	
	TE1 (* 1)	t tala e			into place?	,	
		e reviewed with the Executive			·Maintenance/ED will compl	ete	
	· · · · · · · · · · · · · · · · · · ·	enance Director and the Field			a POC CQI audit tool for six		
	_	visor during the exit			months with audits being		
	conference.				completed once weekly for on		
	2.1.10/13				month, and then monthly for 6		
	3.1-19(b)				months by		
					Maintenance/Designee. The F		
					CQI audit tool will be reviewed	I	
					monthly by the CQI committee		
					six months after which the CC	I	
					team will re-evaluate the conti	nued	
					need for the audit. If a 95%		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155329		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	X3) DATE SURVEY COMPLETED 02/22/2024
	PROVIDER OR SUPPLIER ALK VILLAGE	1302 N	ADDRESS, CITY, STATE, ZIP COD I LESLEY AVE NAPOLIS, 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
			threshold is not achieved an ac plan will be developed	ction
			By What date will the systematic changes be completed? ·Compliance date 3/11/2024	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 1. Based on observation and interview, the facility failed to ensure 1 of 26 portable fire extinguishers was given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, at Section 7.3.1.1.1 requires that fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 3.3.15 defines extinguisher maintenance as a thorough examination of the fire extinguisher that is intended to give maximum assurance that a fire extinguisher will operate effectively and safely and to determine if physical damage or condition will prevent its operation, if any repair or replacement is necessary, and if hydrostatic testing or internal maintenance is required. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could	K 0355	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ·Fire extinguisher in supply room by south nurse station wi be inspected will be maintenartimely once a year. ·All fire extinguishers will be inspected annually. How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be taken. All residents have the potent to be affected by the alleged deficient practice. ·The fire extinguisher by Sou nurse station by supply room he been serviced.	II nce I n? tial

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155329		IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	X3) DATE SURVEY COMPLETED 02/22/2024	
	PROVIDER OR SUPPLIEF	R	1302 N	ADDRESS, CITY, STATE, ZIP COD LESLEY AVE JAPOLIS, IN 46219	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	affect 10 residents,	staff and visitors in the		·The fire extinguisher located	in
	vicinity of the Nurs	ing Supply room by the south		the classroom has been service	
	nurse's station.			·All fire extinguishers were	
				inspected by maintenance dire	ctor
	Findings include:			/designee to ensure all have be	
				inspected at least annually.	
	Based on observation	ons with the Maintenance		'	
	Director and the Fig	eld Maintenance Supervisor		What measures will be put int	to
		facility from 11:45 a.m. to 2:05		place or what systemic	
	p.m. on 02/22/24, t	he fire extinguisher inspection		changes you will make to	
	contractor had affix	ted a hanging tag to the ABC		ensure that the deficient	
	type portable fire ex	xtinguisher in the Nursing		practice does not recur?	
	Supply room by the	e south nurse's station		·An in-service will be complet	ted
	indicating the most	recent annual inspection was		by ED/Designee with maintena	nce
	performed in June 2	2022. Based on interview at the		personnel to ensure compliance	
	time of the observa	tions, the Maintenance		with all mandatory requirement	
	Director and the Fig	eld Maintenance Supervisor		for fire extinguishers maintenar	
	agreed the most rec	ent annual inspection for the		How the corrective action (s)	
	aforementioned por	table fire extinguisher was		will be monitored to ensure th	ne
	more than one year	old.		deficient practice will not	
				recur, i.e., what quality	
	These findings wer	e reviewed with the Executive		assurance program will be pu	ıt
	Director, the Maint	enance Director and the Field		into place?	
	Maintenance Super	visor during the exit		Maintenance/ED will comple	te
	conference.			a POC CQI audit tool for six	
				months with audits being	
	3.1-19(b)			completed once weekly for one	;
				month, and then monthly for 6	
	2. Based on observa	ation and interview, the facility		months by	
	failed to ensure 1 of 26 portable fire extinguishers			Maintenance/Designee. The Po	oc
		ear maintenance documented		CQI audit tool will be reviewed	
		n accordance with NFPA 10.		monthly by the CQI committee	
		ition, Section 7.3.1.1.2 states fire		six months after which the CQI	
	_	be internally examined at		team will re-evaluate the contin	nued
		ling those specified in Table		need for the audit. If a 95%	
		7.3.1.2.1 states every six years,		threshold is not achieved an ac	ction
	_	extinguishers that require a		plan will be developed	
	12-year hydrostatic	test shall be emptied and			
	subjected to the app	blicable internal examination		By What date will the	

procedure as detailed in the manufacturer's

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systematic changes be

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155329	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	COM	E SURVEY PLETED 2/2024		
NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE		1302 N	STREET ADDRESS, CITY, STATE, ZIP COD 1302 N LESLEY AVE INDIANAPOLIS, IN 46219					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE		
IAU	service manual and through 7.3.3.2 stat the applicable 6-yer maintenance inform weatherproof label inches by 3.5 inche the shell and shall i maintenance was perior include the initials of maintenance and the performing the maintenance and the performing the maintenance or practice could affect visitors in the vicin. Findings include: Based on observation Director and the Finduring a tour of the p.m. on 02/22/24, the portable fire exting was manufactured in maintenance was performed in June 10 miles and 10	this standard. Sections 7.3.3.1 the fire extinguishers that pass ar requirement shall have the nation recorded on a durable that is a minimum size of 2 to reliable shall be affixed to include the month and year the extromed. The label shall of the person performing the ename of the agency intenance. A verification of the located around the neck of the ting the month and year of the of the agency performing recharge. This deficient to over 10 residents, staff and the of the Classroom. The wall mounted ABC type in the content of the ename of the ename of the ename of the classroom in 2008. The 6-year and collar affixed to the the most recent 6-year extromed in July 2014. The fire the tion contractor affixed and the tag to the fire extinguisher recent annual maintenance are 2023. Based on interview deservations, the Maintenance stend Maintenance Supervisor tenance for the portable fire verdue as of July 2020.	IAU	completed? ·Compliance date 3/8	8/2024	DATE		
	Director, the Maint	enance Director and the Field						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M				E SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>01</u>		COMPLETED		
155329		B. W	B. WING 02/22/202			2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				LESLEY AVE		
ROSEWA	ALK VILLAGE			INDIAN	IAPOLIS, IN 46219		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Maintenance Superv	visor during the exit					
	conference.						
	3.1-19(b)						
K 0361	NFPA 101						
SS=E	Corridors - Areas	Open to Corridor					
Bldg. 01	Corridors - Areas						
-		n patient sleeping rooms,					
	treatment rooms a	nd hazardous areas),					
	waiting areas, nurs	se's stations, gift shops,					
	•	ies, open to the corridor are					
	in accordance with	the criteria under 18.3.6.1					
	and 19.3.6.1.						
	18.3.6.1, 19.3.6.1						
		on and interview, the facility	K 0	361	What corrective action(s) will	i	03/08/2024
		1 DON offices was separated			be accomplished for those		
		y a partition capable of e of smoke as required in a			residents found to have been	1	
		or met an Exception per			affected by the deficient practice?		
		9.3.6.1(7) states that spaces			·The DON office will be equi	nned	
		eeping rooms, treatment			with an electrically supervised	ppeu	
	-	us areas shall be open to the			smoke detector.		
		ted in area, provided: (a) The			Smoke detector.		
		which the space opens onto			How will you identify other		
	-	compartment are protected by			residents having the potentia	al	
	an electrically super	vised automatic smoke			to be affected by the same		
	detection system in	accordance with 19.3.4, and			deficient practice and what		
	(b) Each space is pro	otected by an automatic			corrective action will be take	n?	
	-	The space does not to obstruct			·All residents have the poten	ıtial	
		xits. This deficient practice			to be affected by the alleged		
		residents, staff and visitors in			deficient practice.		
	•	rirector of Nursing (DON)			·An electrically supervised		
	office by the main d	ining room.			smoke detector has been insta	alled	
	Eindings in abids:				on 3/1/2024.		
	Findings include:				What measures will be set in	ıto.	
	Rased on observation	ons with the Maintenance			What measures will be put in	เบ	
		ld Maintenance Supervisor			place or what systemic changes you will make to		
		-			ensure that the deficient		
during a tour of the facility from 11:45 a.m. to 2:05				Silvare that the delicient			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155329		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 02/22/2024
	PROVIDER OR SUPPLIER ALK VILLAGE	1302 N	ADDRESS, CITY, STATE, ZIP COD LESLEY AVE JAPOLIS, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	p.m. on 02/22/24, a sliding glass door was in the corridor wall to the DON office by the main dining room. The DON office was equipped with a corridor door and a ceiling mounted battery operated smoke detector, but the room was not equipped with an electrically supervised smoke detector. Based on interview at the time of the observations, the Maintenance Director and the Field Maintenance Supervisor agreed the sliding glass door to the DON office made the room open to the corridor, but the room was not equipped with an electrically supervised smoke detector. These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		practice does not recur? An in-service will be completed by ED/Designee with maintent personnel to ensure compliant for all mandatory requirement areas open to corridor. How the corrective action (swill be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be printo place? Maintenance/ED will compa POC CQI audit tool for six months with audits being completed once weekly for or month, and then monthly for months by Maintenance/Designee. The ICQI audit tool will be reviewed monthly by the CQI committed six months after which the CQI team will re-evaluate the contineed for the audit. If a 95% threshold is not achieved an aplan will be developed By What date will the systematic changes be completed? Compliance date 3/8/2024	nance ace as for
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155329	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE COMPL 02/22/	ETED	
NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 1302 N LESLEY AVE INDIANAPOLIS, IN 46219				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	capable of resistir minutes. Doors in compartments are passage of smoke to rooms containing combustible material hardware. Roller If CMS regulation. The apply to auxiliary apply to aux	rials have positive latching atches are prohibited by These requirements do not spaces that do not contain abustible material. In bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping then a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are red protective plates of re permitted. Dutch doors are permitted. Door beled and made of steel or compliance with 8.3, compartment is fire window assemblies are in sprinklered compartments ctions in area or fire is or frames in window. Parts 403, 418, 460, 482, as details of doors such as ings, automatics closing	V 0262	What corrective action(a) wi		02/09/2024	
	failed to ensure 1 or resident sleeping ro	on and interview, the facility f over 65 corridor doors to oms would resist the passage icient practice could affect over	K 0363	What corrective action(s) wi be accomplished for those residents found to have bee affected by the deficient		03/08/2024	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SI					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETE				
		155329	B. WING 02/22/2024				024
	PROVIDER OR SUPPLIER		•	1302 N	ADDRESS, CITY, STATE, ZIP COD LESLEY AVE IAPOLIS, IN 46219		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDEDIC DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		nd visitors in the vicinity of			practice?		
	resident sleeping Ro	oom 170.			·Room 170 door to be		
	Findings include:				completely smoke resistant.		
					How will you identify other		
		ons with the Maintenance			residents having the potentia	al	
		eld Maintenance Supervisor			to be affected by the same		
	_	facility from 11:45 a.m. to 2:05			deficient practice and what		
	_	wo separate 1/4th's inch in e noted above and below the			corrective action will be take All residents have the poter	I	
		corridor door to resident			to be affected by the alleged	iudi	
		which would not resist the			deficient practice.		
		Based on interview at the time			·Holes in 170 door were sea	led	
		s, the Maintenance Director			with fire proof caulking and wi		
	and the Field Maint	enance Supervisor agreed the			now resist the passage of smo		
	holes in the corridor	r door to resident Room 170			All doors were checked by		
	would not resist the	passage of smoke.			maintenance director to ensur	е	
					there were holes to prevent th	е	
		e reviewed with the Executive			passage of smoke.		
	· ·	enance Director and the Field					
	-	visor during the exit			What measures will be put in	ito	
	conference.				place or what systemic		
	3 1 10/b)				changes you will make to ensure that the deficient		
	3.1-19(b)				practice does not recur?		
					·An in-service will be complete	eted	
					by ED/Designee with mainten		
					personnel to ensure complian		
					for all mandatory requirements	I	
					Corridor doors.		
					How the corrective action (s)	,	
					will be monitored to ensure t	:he	
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place?		
					·Maintenance/ED will compl	ete	
					a POC CQI audit tool for six		
					months with audits being		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING		ILDING	LE CONSTRUCTION X3) DATE SURVEY G 01 COMPLETED 02/22/2024		LETED		
NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 1302 N LESLEY AVE INDIANAPOLIS, IN 46219				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
					completed once weekly for one month, and then monthly for 6 months by Maintenance/Designee. The PCQI audit tool will be reviewed monthly by the CQI committee six months after which the CQ team will re-evaluate the continued for the audit. If a 95% threshold is not achieved an applan will be developed By What date will the systematic changes be completed? Compliance date 3/8/2024	OC for I nued	

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