STATEMENT OF DEFICIENCIES X1) PROVIDER/SUP		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S		SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION N		IDENTIFICATION NUMBER	A. BU	A. BUILDING			ETED
		155121	B. WING			04/17/	2023
				_	_		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					NION ST		
ROSEWA	ALK VILLAGE AT LA	AFAYETTE		LAFAY	ETTE, IN 47904		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
E 0000	REGUERTORT OR	ESC ISENTIF THIS INFORMATION	+	1710			DATE
L 0000							
Bldg							
ышу	A E		F 0	200			ı
		paredness Survey was	E 00)00			
	-	diana Department of Health in					
	accordance with 42	CFR 483.73.					
	Survey Date: 04/17	7/23					
	Facility Number: 0						
	Provider Number:						
	AIM Number: 1002	275490					
	At this Emergency I	Preparedness survey,					
	Rosewalk Village at	t Lafayette was found in					
	compliance with En	nergency Preparedness					
	-	ledicare and Medicaid					
		lers and Suppliers, 42 CFR					
	483.73	ors and suppliers, 12 erro					
	105175						
	The facility has 141	certified beds. At the time of					
	the survey, the cens						
	the survey, the cons	us wus 102.					
	Quality Review con	anleted on 04/19/23					
	Quanty Review con	ipicted on 04/19/23					
K 0000							
1, 0000							
Bldg. 01							
Diag. 01	A Life Sofety Code	Recertification and State	K 0	000			l
		as conducted by the Indiana	KU	000			
		th in accordance with 42 CFR					
	483.90(a).						
	S 5 04/4	V/0.0					
	Survey Date: 04/17	/23					
	- H	000-74					
	Facility Number: 0						
	Provider Number:						
	AIM Number: 1002	275490					
	At this Life Safety (Code survey, Rosewalk Village					

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

TITLE (X6) DATE

Nathan Anderson Executive Director 05/03/2023

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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: SWQU21 Facility ID: 000051 If continuation sheet Page 1 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155121	B. WING		04/17/2023	
	ROVIDER OR SUPPLIER		1903	T ADDRESS, CITY, STATE, ZIP COD UNION ST YETTE, IN 47904		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROWIDERIG BY AN OF CORRECTION	(X5)	
PREFIX			PREFIX	PROVIDER'S PLAN OF CORRECTION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	at Lafayette was for	and not in compliance with				
	Requirements for Pa	-				
		, 42 CFR Subpart 483.90(a),				
	-	re and the 2012 edition of the				
		ction Association (NFPA) 101,				
	•	LSC), Chapter 19, Existing				
	Health Care Occupa	ancies and 410 IAC 16.2.				
	This feetling in fall	ranninklared and someist-1-f				
		sprinklered and consisted of: a of Type V (000) construction				
		lding determined to be Type V				
	_	was surveyed as two building				
		construction Types. The				
		arm system with hard wired				
	•	the corridors and spaces open				
	to the corridors. Res	sident rooms are equipped				
	with battery powere	ed smoke detectors. The				
	facility has the capa	icity for 141 residents and had				
	a census of 102 at the	he time of this survey.				
	All areas where resi	idents have customary access				
		he facility has two detached				
	equipment storage b	ouildings which were not				
	sprinklered.					
	Quality Review con	npleted on 04/19/23				
K 0225	NFPA 101					
SS=F		okeproof Enclosures				
Bldg. 01	-	okeproof Enclosures				
	-	nokeproof enclosures used				
	as exits are in acc	-				
	18.2.2.3, 18.2.2.4,	, 19.2.2.3, 19.2.2.4, 7.2				
		on and interview, the facility	K 0225	K- 255 Stairways and	05/01/2023	
	•	continuous protected path of		Smokeproof Enclosures		
		charge for 4 of 4 stairwell exits		It is the practice of this provide		
		LSC section 7.2 Means of		ensure exit access is arrange		
		s. LSC 7.2.3.5.1 requires every		that exits are readily accessib	le at	
	_	ure shall discharge into a		all times.		
	public way, into a y	ard or court having direct				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SWQU21 Facility ID: 000051

If continuation sheet Page 2 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155121		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/17/2023	
	ROVIDER OR SUPPLIEF		1903 L	ADDRESS, CITY, STATE, ZIP COD JNION ST /ETTE, IN 47904	
(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
TAG	access to a public we passageway. Such exit without openings of smoke proof enclose outside yard, court, passageway shall be of the building by a rating. This deficient residents, staff, and facility from the section of the section	ray, or into an exit exit passageways shall be ther than the entrance from the ture and the door to the or public way. The exit exparated from the remainder two-hour fire resistance at practice could affect all visitors if needing to exit the cond floor. The same of the facility from 11:26 to 104/18/23, all four of four exit excharge into a public way, into an direct access to a public passageway. Based on the observations, the exist agreed that all four of the within the facility did not to blic way, into an diadded that he thought the refor this deficiency. It was the facility Administrator that the ting an Fire Safety Evaluation etermine compliance. Wiewed with the Maintenance Executive Director at the exit	TAG	What corrective action(s) where accomplished for those residents found to have been affected by the deficient practice: No residents were affected, a facility passed the Fire Safety Evaluation System (FSES) where was completed on 5/1/23. How other residents having the potential to be affected the same deficient practice be identified and what corrective action(s) will be taken: No residents were affected, a facility passed the Fire Safety Evaluation System (FSES) where was completed on 5/1/23. What measures will be put if place and what systemic changes will be made to ensure that the deficient practice does not recur: FSES was completed on 5/1/2 which indicates the facility melevel of LSC equivalent to the prescribed NFPA 101, LSC for Health Care Occupancy. See attached document. How the corrective action(s will be monitored to ensure	ill en as / chich by will as / chich nto /23, et the en en cor e
				deficient practice will not	

PRINTED: 05/11/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155121		A. BUILDING B. WING	01	COMPLETED 04/17/2023	
	ROVIDER OR SUPPLIER		1903 U	ADDRESS, CITY, STATE, ZIP COD NION ST ETTE, IN 47904	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas Hazardous Areas Hazardous areas barrier having 1-ho (with 3/4 hour fire automatic fire extir accordance with 8 approved automat option is used, the from other spaces partitions and door Doors shall be self automatic-closing nonrated or field-a do not exceed 48 if the door.	- Enclosure - Enclosure are protected by a fire our fire resistance rating rated doors) or an aguishing system in 7.1 or 19.3.5.9. When the ic fire extinguishing system areas shall be separated by smoke resisting as in accordance with 8.4. f-closing or and permitted to have pplied protective plates that inches from the bottom of	TAG	recur, i.e., what quality assurance program will be p into place: FSES was completed on 5/1/2 which indicates the facility me level of LSC equivalent to the prescribed NFPA 101, LSC fo Health Care Occupancy. See attached document. ED will ensure FSES is conducted annually By what date the systemic changes for each deficiency will be completed: Compliance date: 5/1/23	ut 23, t the

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SWQU21 Facility ID: 000051

If continuation sheet

Page 4 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155121		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/17/2023	
	PROVIDER OR SUPPLIER		1903 L	ADDRESS, CITY, STATE, ZIP COD JNION ST /ETTE, IN 47904	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	b. Laundries (large c. Repair, Mainten d. Soiled Linen Rogallons) e. Trash Collection (exceeding 64 galf. Combustible Sto (over 50 square feg. Laboratories (if Hazard - see K322 Based on observation failed to ensure the hazardous areas, sur Keeping/Bio-hazard combustible supplied was provided with a would cause the dool latch into the door frould affect as many visitor in the facility. Findings include: Based on observation Supervisor during a p.m. on 04/18/23, roused for storage of a cardboard. There we by 12 inch high by the room creating a the corridor of this a self-closing device, device on the corridor was acknowledged Supervisor who states.	Fired Heater Rooms or than 100 square feet) ance, and Paint Shops owns (exceeding 64 on Rooms (exceeding 64 on Rooms dons) orage Rooms/Spaces eet) classified as Severe (2) on and interview, the facility corridor door to 1 of over 25 och as a House of the room, a storage room of the so over 50 square feet in size, a self-closing device which or to automatically close and frame. This deficient practice by as 20 residents, 3 staff, and 1 och with the Maintenance tour of the facility at 12:31 ons with the	K 0321	K 321 Hazardous Areas- Enclosure What corrective action(s) wibe accomplished for those residents found to have bee affected by the deficient practice: The new overbed lights in cardboard were immediately removed from the resident roothous deficient practice will identified and what correctivation(s) will be taken: 20 residents, 3 staff and 1 vis have the potential to be affect by deficient practice. A facility audit will be conducted to enside the potential to be affect by deficient practice. A facility audit will be conducted to enside the potential to be affect by deficient practice. A facility audit will be conducted to enside the potential to be affect by deficient practice. A facility audit will be conducted to enside the potential to be affect by deficient practice. A facility audit will be conducted to enside the potential to be affect by deficient practice. A facility audit will be conducted to enside the potential to be affect by deficient practice. A facility audit will be conducted to enside the potential to be affect by deficient practice. A facility audit will be conducted to enside the potential to be affect by deficient practice. A facility audit will be conducted to enside the potential to be affect by deficient practice. A facility audit will be conducted to enside the potential to be affect by deficient practice. A facility audit will be conducted to enside the potential to be affect by deficient practice.	n the ne be ve itor ded ve sthout

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SWQU21 Facility ID: 000051

If continuation sheet Page 5 of 16

PRINTED: 05/11/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155121		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 04/17/2023	
	PROVIDER OR SUPPLIE		1903 U	ADDRESS, CITY, STATE, ZIP COD INION ST 'ETTE, IN 47904	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
		eviewed with the Maintenance Executive Director at the exit 7/23 at 2:00 p.m.		place and what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance staff will be in-serviced on storage of hazardous materials on or be 5/17/23. Maintenance or desi will continue to observe the storage of hazardous material ensure there are no in correct stored items weekly or more as needed. How the corrective action(s will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place: Ongoing compliance with this corrective action will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program (QAPI Maintenance Director/design will be responsible for complet the QAPI Audit tool "Life Safe POC" monthly for 4 months a quarterly thereafter for at least quarters. If threshold of 90% met, an action plan will be submitted to the QAPI Comm for review and follow up. By what date the systemic changes for each deficiency will be completed:	ignee als to tity often the put stored 1). The ee eting ety and st 2 is not nittee

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $SWQU21 \quad \text{Facility ID:} \quad 000051$

If continuation sheet

Page 6 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING	(X3) DATE SURVEY COMPLETED		
		155121	B. WING 04/17/2023		
	PROVIDER OR SUPPLIEI		1903 ເ	ADDRESS, CITY, STATE, ZIP COD JNION ST /ETTE, IN 47904	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY 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)	(X5) COMPLETION DATE
				Compliance Date: 5/17/23	
K 0345 SS=E Bldg. 01	in accordance with complying with the National Electric Control National Fire Alar Records of system and testing are respected in the National Fire Alar Records of system and testing are respected in the National Nation	m - Testing and m is tested and maintained h an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. m acceptance, maintenance	K 0345	K 345 Fire Alarm System-Testing and Maintenance What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The smoke detector was immediately mounted flush on ceiling. How other residents having a potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: 18 residents, 3 staff and 1 visi have the potential to be affected by deficient practice. Smoke detectors were audited to ensithey are mounted flush to the ceiling.	the the e pe e tor ed

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SWQU21 Facility ID: 000051

If continuation sheet Page 7 of 16

PRINTED: 05/11/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION OF CORRECTION 155121	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/17/2023
	PROVIDER OR SUPPLIER ALK VILLAGE AT LAFAYETTE	1903 U	ADDRESS, CITY, STATE, ZIP COD NION ST ETTE, IN 47904	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	ceiling and into the sensing chamber of the smoke detector. Based on interview at the time of the observation, the Maintenance Supervisor acknowledged the previously mentioned smoke detector as not being mounted flush with the ceiling and said he would correct it as soon as possible. This finding was reviewed with the Maintenance Supervisor and the Executive Director at the exit conference on 04/17/23 at 2:00 p.m. 3.1-19(b)		What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance staff will be in-serviced on mounting and maintaining smoke detectors to before 5/17/23. Maintenance of designee will continue to obsess moke detectors to ensure the are mounted flush to the ceilin weekly or more often as need. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be pinto place: Ongoing compliance with this corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be pinto place: Ongoing compliance with this corrective action will be monitored to the facility Quality Assurance and Performance Improvement Program (QAPI) Maintenance Director/designed will be responsible for complethe QAPI Audit tool "Life Safet POC" monthly for 4 months are quarterly thereafter for at least quarters. If threshold of 90% is met, an action plan will be developed. Findings will be submitted to the QAPI Commit for review and follow up. By what date the systemic changes for each deficiency will be completed:	on or or or or erve eay ig ed. the ut ored The etting eay in det 2 is not ittee

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SWQU21 Facility ID: 000051

If continuation sheet

Page 8 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155121		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED B. WING 04/17/2023			
	PROVIDER OR SUPPLIER		1903 U	ADDRESS, CITY, STATE, ZIP COD INION ST 'ETTE, IN 47904	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0355 SS=E	NFPA 101 Portable Fire Extir			Compliance Date: 5/17/23	
Bldg. 01	installed, inspecte accordance with N Portable Fire Extir 18.3.5.12, 19.3.5. Based on observation failed to ensure 2 of the Maintenance of accordance with NF Fire Extinguishers, states portable fire the wheeled extinguisher of the following me intended for the extisupplied by the extillisted bracket appro	guishers are selected, d, and maintained in IFPA 10, Standard for nguishers. 12, NFPA 10 on and interview, the facility 2 portable fire extinguishers in fice were installed in FPA 10, Standard for Portable 2010 Edition. Section 6.1.3.4 extinguishers other than ers shall be installed using any ans. (1) Securely on a hanger inguishers. (2) In the bracket nguisher manufacture. (3) In a ved for such purpose. (3) In a	K 0355	K 355 Portable Fire Extinguishers What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The two fire extinguishers were immediately removed and storcorrectly.	n re
	could affect as many visitor. Findings include: Based on observation Supervisor during a p.m. on 04/18/23, to extinguisher located Supervisors office where the supervisors of the work mounted or protein the supervisors was supervisors w	ons with the Maintenance tour of the facility at 12:46 wo ABC portable fire I in the Maintenance vere sitting on the floor and ected from falling. Based on e of observation, the visor acknowledged the atting on the floor and were ected from falling over adding them to a safe place		How other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents and staff have the potential to be affected by deficient practice. An audit of extinguishers will be conducted ensure they are stored correct. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur:	e e fire ed to tly.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SWQU21 Facility ID: 000051

If continuation sheet

Page 9 of 16

PRINTED: 05/11/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155121	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	COMP	E SURVEY PLETED 7/2023
	ROVIDER OR SUPPLIER		1903 L	ADDRESS, CITY, STATE, ZIP C INION ST ŒTTE, IN 47904	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE / DEFICIENCY)	RRECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
IAU	immediately. This finding was re	viewed with the Maintenance Executive Director at the exit	IAG	Maintenance staff will in-serviced on storing extinguishers on or be Maintenance or design continue to observe fir extinguishers to ensure correctly weekly or moneeded. How the corrective as will be monitored to extinguishers to ensure correctly weekly or moneeded. How the corrective as will be monitored to extend the deficient practice will recur, i.e., what quality assurance program winto place: Ongoing compliance we corrective action will be through the facility Quarksurance and Perform Improvement Program Maintenance Director/will be responsible for the QAPI Audit tool "Li POC" monthly for 4 medianters. If threshold of met, an action plan will developed. Findings we submitted to the QAPI for review and follow undeveloped for each definition will be completed: Compliance Date: 5/17	be fire fore 5/17/23. nee will the eare stored one often as ction(s) ensure the land will be put with this the monitored ality mance in (QAPI). The designee completing if e Safety conths and that least 2 of 90% is not libe will be Committee in Committe	DATE
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Deco					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SWQU21 Facility ID: 000051

If continuation sheet

Page 10 of 16

AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155121		lì í	UILDING	onstruction 01	(X3) DATE COMPL 04/17 /	ETED		
		ER OR SUPPLIER		•	1903 UI	ADDRESS, CITY, STATE, ZIP COD NION ST ETTE, IN 47904		
(X4) PREF TA	FIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	(EACH CORRECTIVE A CTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
	unless on I fire-r for property of I than 289. The second of I fire of I fir	ss one of the Flame retardate etardant coat roduct. Decorations of 100 kilowatts Decorations, ings and other, ceilings and other, ceilings and other, ceilings and other of the decoration such limited evelopment of 5.6 do nobservation of the decoration and affect as mannor in the facility may be include: I do nobservation of the ception was mannor in the facility may be include: I do nobservation of the ception was mannor in the facility may be include: I do nobservation of the ception was mannor in the facility may be include: I do nobservation of the ception was mannor in the facility may be include: I do nobservation of the ception was mannor in the facility may be included on observation of the ception was and one of the terview at the facility was the finistrator acknown the finistrator acknown the finistrator acknown the facility of the fac	rations shall be prohibited following is met: ant or treated with approved ing that is listed and labeled meet NFPA 701. Exhibit heat release less in accordance with NFPA such as photographs, ar art are attached to the linon-fire-rated doors in 8.7.5.6(4) or 19.7.5.6(4). One in existing occupancies in quantities that a hazard of for spread is not present. This deficient practice by as 16 residents, 3 staff, and 1 or some with the Maintenance of tour of the facility from 11:26 on 04/18/23, resident room #242 andles in it. All five candles and a burnt wick in it. Based time of observation, the facility owledged the aforementioned andles with wicks located the would ask the resident to on as he was able to do so. Viewed with the Maintenance Executive Director at the exit	K 0	753	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The five candles were immeding removed from the resident's removed from the resident shaving the same deficient practice will be identified and what corrective action(s) will be taken: All residents and staff have the potential to be affected by deficient practice. An audit of resident rooms to ensure there no combustible decorations we conducted. What measures will be put in	ately com. the se ce e are ill be	05/17/2023

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SWQU21 Facility ID: 000051

If continuation sheet Page 11 of 16

PRINTED: 05/11/2023 FORM APPROVED OMB NO. 0938-039

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 155121	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 04/17/2023
	ROVIDER OR SUPPLIER ALK VILLAGE AT LAFAYETTE	1903 U	ADDRESS, CITY, STATE, ZIP COD NION ST ETTE, IN 47904	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	conference on 04/17/23 at 2:00 p.m. 3.1-19(b)		place and what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance staff will be in-serviced on combustible decorations on or before 5/17/ Maintenance or designee will continue to observe resident rooms to ensure there are no combustible decorations week more often as needed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be pinto place: Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI) Maintenance Director/designe will be responsible for completing the QAPI Audit tool "Life Safet POC" monthly for 4 months are quarterly thereafter for at least quarters. If threshold of 90% is met, an action plan will be submitted to the QAPI Commifor review and follow up. By what date the systemic changes for each deficiency will be completed: Compliance Date: 5/17/23	the ut ored The eting ty and t 2 s not ttee

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SWQU21 Facility ID: 000051

If continuation sheet Page 12 of 16

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA				î ′	(3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER						COMPL		
		155121	B. W.	NG		04/17/	2023	
NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT LAFAYETTE			STREET ADDRESS, CITY, STATE, ZIP COD 1903 UNION ST LAFAYETTE, IN 47904					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDENCE BLANCE CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	rc	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		L	DATE	
K 0911 SS=E Bldg. 01	Electrical Systems List in the REMAR Chapter 6 Electrica that are not addres K-Tags, but are de along with the app NFPA standard cit on Form CMS-256 Chapter 6 (NFPA) Based on observation failed to ensure access maintained in enclose apparatus in 1 of 1 M office. NFPA 99, He Edition, Section 6.3 shall be in accordan Electric Code. NFPA 110.26 states workin operating at 600 vol to require examinating maintenance while of dimensions of 110.2 shall be measured from opening if such are states the working s shall not be used for practice could affect Findings include: Based on observation Supervisor during a	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) Based on observation and interview, the facility failed to ensure access and working space was maintained in enclosures housing electrical apparatus in 1 of 1 Maintenance Supervisors office. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.1 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states working space for equipment operating at 600 volts, nominal, or less and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2) and (3). Distances shall be measured from the live parts if such parts are exposed or from the enclosure front or opening if such are enclosed. Article 110.26(B) states the working space required by this section shall not be used for storage. This deficient practice could affect as many as		911	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 911 Electrical Systems- Other What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The items were immediately removed from the three feet of working space in front of the electrical panels. How other residents having the potential to be affected by deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by deficient practice. All electrical panels will be audited to ensure no items are stored within three feet of space in front of the electrical panels. The electrical panel will have a designated three foot hazard area		05/17/2023	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SWQU21 Facility ID: 000051

If continuation sheet Page 13 of 16

am	m on prove	Later and a service and a serv			NAME AND ADDRESS OF THE PARTY O	5111	
STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
155121		B. WING			04/17/	/2023	
NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT LAFAYETTE			STREET ADDRESS, CITY, STATE, ZIP COD 1903 UNION ST LAFAYETTE, IN 47904				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
TAG	ladder, a tool chest warning cones. Bas the observations, th acknowledged the a stored within three front of electrical pa Supervisors office.	on wheels, and four orange ed on interview at the time of e Maintenance Supervisor uforementioned items were feet of the working space in anels in the Maintenance viewed with the Maintenance Executive Director at the exit		TAG	What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance staff will be in-serviced on storing items in from of electrical panels on or before 5/17/23. Maintenance designee will continue to obselectrical panels to ensure no items are stored three feet in of them weekly more often as needed. How the corrective action(s) will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be pinto place: Ongoing compliance with this corrective action will be monitored to ensure the pinto place: Ongoing compliance with this corrective action will be monitored to ensure the pinto place: Ongoing compliance with this corrective action will be monitored to ensure the pinto place: Ongoing compliance with this corrective action will be monitored to ensure the pinto place. Ongoing compliance with this corrective action will be monitored to ensure the pintoplace. Ongoing compliance with this corrective action will be monitored to ensure the pintoplace. Ongoing compliance with this corrective action will be monitored to ensure the pintoplace. Ongoing compliance with this corrective action will be monitored to ensure the pintoplace. Ongoing compliance with this corrective action will be monitored to ensure the pintoplace. Ongoing compliance with this corrective action will be monitored to ensure the pintoplace.	or erve front the ut ored o. The ee ting ty and t 2 s not	DATE
1			1		changes for each deficiency		I

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 155121	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 04/17/2023			
ROSEW	PROVIDER OR SUPPLIER ALK VILLAGE AT LAFAYETTE	STREET ADDRESS, CITY, STATE, ZIP COD 1903 UNION ST LAFAYETTE, IN 47904					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
			will be completed: Compliance Date: 5/17/23				
K 0000							
Bldg. 02	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: 04/17/23 Facility Number: 000051 Provider Number: 155121 AIM Number: 100275490 At this Life Safety Code survey, Rosewalk Village 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 facility is fully sprinklered and consisted of: a one-story building of Type V (000) construction and a two-story building determined to be Type V (111). The facility was surveyed as two building due to the different construction Types. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has the capacity for 141 residents and had a census of 102 at the time of this survey.	K 0000					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SWQU21 Facility ID: 000051

If continuation sheet

Page 15 of 16

PRINTED: 05/11/2023 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 02			COMPLETED		
		155121	B. WING			04/17/2023	
	PROVIDER OR SUPPLIER			1903 UI	ADDRESS, CITY, STATE, ZIP COD NION ST ETTE, IN 47904		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE
	were sprinklered. T	dents have customary access he facility has two detached ouildings which were not					

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: SWQU21 Facility ID: 000051 If continuation sheet Page 16 of 16