STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155121	A. BUILDING -- B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEWALK VILLAGE AT LAFAYETTE	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 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: 04/17/23 Facility Number: 000051 Provider Number: 155121 AIM Number: 100275490 At this Emergency Preparedness survey, Rosewalk Village at Lafayette was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 141 certified beds. At the time of the survey, the census was 102. Quality Review completed on 04/19/23	E 0000		
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: 04/17/23 Facility Number: 000051 Provider Number: 155121 AIM Number: 100275490 At this Life Safety Code survey, Rosewalk Village	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nathan Anderson	Executive Director	05/03/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	155121	A. BUILDING 01 B. WING	04/17/2023

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ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION ST LAFAYETTE, IN 47904

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	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. All areas where residents have customary access were sprinklered. The facility has two detached equipment storage buildings which were not sprinklered. Quality Review completed on 04/19/23			
K 0225 SS=F Bldg. 01	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 Based on observation and interview, the facility failed to provide a continuous protected path of travel to an exit discharge for 4 of 4 stairwell exits in accordance with LSC section 7.2 Means of Egress Components. LSC 7.2.3.5.1 requires every smoke proof enclosure shall discharge into a public way, into a yard or court having direct	K 0225	**K- 255 Stairways and Smokeproof Enclosures** It is the practice of this provider to ensure exit access is arranged so that exits are readily accessible at all times.	05/01/2023

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	155121	A. BUILDING 01 B. WING	04/17/2023

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ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION ST LAFAYETTE, IN 47904

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	access to a public way, or into an exit passageway. Such exit passageways shall be without openings other than the entrance from the smoke proof enclosure and the door to the outside yard, court, or public way. The exit passageway shall be separated from the remainder of the building by a two-hour fire resistance rating. This deficient practice could affect all residents, staff, and visitors if needing to exit the facility from the second floor. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 11:26 a.m. to 1:55 p.m. on 04/18/23, all four of four exit stairwells do not discharge into a public way, into a yard or court having direct access to a public way, or into an exit passageway. Based on interview at the time of the observations, the Maintenance Supervisor agreed that all four of the four exit stairwells within the facility did not discharge into a public way, into a yard or court having direct access to a public way, or into an exit passageway and added that he thought the facility had a waiver for this deficiency. It was later learned from the facility Administrator that they will be conducting an Fire Safety Evaluation System (FSES) to determine compliance. 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 corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were affected, as facility passed the Fire Safety Evaluation System (FSES) which was completed on 5/1/23. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** No residents were affected, as facility passed the Fire Safety Evaluation System (FSES) which was completed on 5/1/23. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** FSES was completed on 5/1/23, which indicates the facility met the level 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 the deficient practice will not**	

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	155121	A. BUILDING 01 B. WING	04/17/2023

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			recur, i.e., what quality assurance program will be put into place: FSES was completed on 5/1/23, which indicates the facility met the level of LSC equivalent to the prescribed NFPA 101, LSC for 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**	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9			

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ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION ST LAFAYETTE, IN 47904

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	Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure the corridor door to 1 of over 25 hazardous areas, such as a House Keeping/Bio-hazard room, a storage room of combustible supplies over 50 square feet in size, was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect as many as 20 residents, 3 staff, and 1 visitor in the facility. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility at 12:31 p.m. on 04/18/23, resident room #130 was being used for storage of new overbed lights stored in cardboard. There were a total of 27 10 inch wide by 12 inch high by 60-inch-long boxes stacked in the room creating a hazardous area. The door to the corridor of this room was not provided with a self-closing device. The lack of a self-closing device on the corridor door to resident room #130 was acknowledged by the Maintenance Supervisor who stated that he would have the boxes moved as soon as he was able to do so.	K 0321	**K 321 Hazardous Areas-Enclosure** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The new overbed lights in cardboard were immediately removed from the resident room. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** 20 residents, 3 staff and 1 visitor have the potential to be affected by deficient practice. A facility audit will be conducted to ensure there no other stored supplies creating a hazardous area without a self-closing device. **What measures will be put into**	05/17/2023

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	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)		**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 before 5/17/23. Maintenance or designee will continue to observe the storage of hazardous materials to ensure there are no in correctly stored items weekly or 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 put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool “Life Safety POC” monthly for 4 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. **By what date the systemic changes for each deficiency will be completed:**	

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			Compliance Date: 5/17/23	
K 0345 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72. NFPA 72, Section 17.7.3.1.1 states the location and spacing of smoke detectors shall be based upon the anticipated smoke flows due to the plume and ceiling jet produced by the anticipated fire, as well as any pre-existing ambient airflows that could exist in the protected compartment. This deficient practice could affect at least 18 residents, 3 staff, and 1 visitor. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility at 12:46 p.m. on 04/18/23, the ceiling mounted smoke detector in the "Family room" was not mounted flush on the ceiling with an approximate gap of one inch between the ceiling mount and the ceiling. With the one-inch gap between the ceiling and the smoke detector, it could not be assured that the one-inch gap would not interfere with the transport of the smoke upward and across the	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 the ceiling. **How other residents having the 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 visitor have the potential to be affected by deficient practice. Smoke detectors were audited to ensure they are mounted flush to the ceiling.	05/17/2023

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	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 into 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 on or before 5/17/23. Maintenance or designee will continue to observe smoke detectors to ensure they are mounted flush to the ceiling weekly or 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 put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool “Life Safety POC” monthly for 4 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. **By what date the systemic changes for each deficiency will be completed:**	

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K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers 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 Based on observation and interview, the facility failed to ensure 2 of 2 portable fire extinguishers in the Maintenance office were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (3) In a cabinet or wall recess. This deficient practice could affect as many as 18 residents, 3 staff, and 1 visitor. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility at 12:46 p.m. on 04/18/23, two ABC portable fire extinguisher located in the Maintenance Supervisors office were sitting on the floor and not mounted or protected from falling. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the extinguishers was sitting on the floor and were not mounted or protected from falling over adding that he would move them to a safe place	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 stored correctly. **How other residents having the 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 fire extinguishers will be conducted to ensure they are stored correctly. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:**	05/17/2023

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	immediately. 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)		Maintenance staff will be in-serviced on storing fire extinguishers on or before 5/17/23. Maintenance or designee will continue to observe fire extinguishers to ensure are stored correctly weekly or 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 put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool “Life Safety POC” monthly for 4 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. **By what date the systemic changes for each deficiency will be completed:** Compliance Date: 5/17/23	
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations			

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	Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6			
	Based on observation and interview, the facility failed to ensure 1 of 84 resident rooms was maintained in accordance with 19.7.5.6. LSC 19.7.5.6 prohibits combustible decorations unless an exception was met. This deficient practice could affect as many as 16 residents, 3 staff, and 1 visitor in the facility. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 11:26 a.m. to 1:55 p.m. on 04/18/23, resident room #242 had a total of five candles in it. All five candles had wicks and one had a burnt wick in it. Based on interview at the time of observation, the facility Administrator acknowledged the aforementioned resident room had candles with wicks located within it stating that he would ask the resident to remove them as soon as he was able to do so. This finding was reviewed with the Maintenance Supervisor and the Executive Director at the exit	K 0753	**K 753 Combustible Decorations** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The five candles were immediately removed from the resident's room. **How other residents having the 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 resident rooms to ensure there are no combustible decorations will be conducted. **What measures will be put into**	05/17/2023

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	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 5/17/23. Maintenance or designee will continue to observe resident rooms to ensure there are no combustible decorations weekly or 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 put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool “Life Safety POC” monthly for 4 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. **By what date the systemic changes for each deficiency will be completed:** Compliance Date: 5/17/23	

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ROSEWALK VILLAGE AT LAFAYETTE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0911 SS=E Bldg. 01	NFPA 101 Electrical Systems - Other 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 Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility at 12:45 p.m. on 04/18/23, four electrical panels were noted on the wall of the Maintenance Supervisors office. These electrical panels were obstructed by a	K 0911	**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 the same 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 colored yellow to ensure no items are stored in front of panels.	05/17/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155121	A. BUILDING 01 B. WING	04/17/2023

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	ladder, a tool chest on wheels, and four orange warning cones. Based on interview at the time of the observations, the Maintenance Supervisor acknowledged the aforementioned items were stored within three feet of the working space in front of electrical panels in the Maintenance Supervisors office. 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 into 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 or designee will continue to observe electrical panels to ensure no items are stored three feet in front of them weekly 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 put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing the QAPI Audit tool “Life Safety POC” monthly for 4 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. **By what date the systemic changes for each deficiency**	

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			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		

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	155121	A. BUILDING 02 B. WING	04/17/2023

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	All areas where residents have customary access were sprinklered. The facility has two detached equipment storage buildings which were not sprinklered.			