						PRIN	TED:	10/20/2022
DEPARTMENT	Γ OF HEALTH AND HU	MAN SERVICES				FORM APPROVED		ROVED
CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0	938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVE	Y
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		<u></u>	COMPLETED		
		155106	B. WI	NG		09/28	/2022	
NAME OF PROVIDER OR SUPPLIER RIVERWALK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 295 WESTFIELD RD NOBLESVILLE, IN 46060					
(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 APPROPRIA	TE.	COMF	PLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		D	ATE
E 0000								

E 0000

conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.

Survey Date: 09/28/22

Facility Number: 000044

Provider Number: 155106

this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.

This provider respectfully requests

At this Emergency Preparedness survey, Riverwalk Village was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73

An Emergency Preparedness Survey was

AIM Number: 100274940

The facility has 169 certified beds. At the time of the survey, the census was 118.

Quality Review completed on 10/03/22

E 0041 SS=C Bldg. --

Bldg. --

482.15(e), 483.73(e), 485.625(e)
Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation:
(e) Emergency and standby power systems.
The hospital must implement emergency and standby power systems based on the

standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section.

(i) and (ii) of this section.

§483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power

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

TITLE

The creation and submission of

that the 2567 Plan of Correction be considered the Letter of

Credible Allegation and requests a

Desk Review on or after October

21, 2022.

(X6) DATE

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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	ENT OF DEFICIENCIES N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155106		LDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 09/28/2022	
	F PROVIDER OR SUPPLIE	R		295 WE	DDRESS, CITY, STATE, ZIP COD STFIELD RD SVILLE, IN 46060		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	1	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION
TAG	systems based or	R LSC IDENTIFYING INFORMATION n the emergency plan set n (a) of this section.		TAG	DEFICIENCY)		DATE
	Emergency gene generator must be the location requiled Care Facilities Countering Amendments 12-4, TIA 12-5, and Code (NFPA 101) Amendments TIA and TIA 12-4), and structure is built of structure or buildid 482.15(e)(2), §48 Emergency gene The [hospital, CA implement the end inspection, testing requirements four	183.73(e)(1), §485.625(e)(1) rator location. The e located in accordance with rements found in the Health ode (NFPA 99 and Tentative ents TIA 12-2, TIA 12-3, TIA and TIA 12-6), Life Safety and Tentative Interim a 12-1, TIA 12-2, TIA 12-3, and NFPA 110, when a new or when an existing ing is renovated. 183.73(e)(2), §485.625(e)(2) rator inspection and testing. I'll and LTC facility] must mergency power system g, and [maintenance] and in the Health Care IFPA 110, and Life Safety					
	Emergency gene and LTC facilities source to power of have a plan for ho	33.73(e)(3), §485.625(e)(3) rator fuel. [Hospitals, CAHs of that maintain an onsite fuel emergency generators must ow it will keep emergency perational during the ss it evacuates.					
	§483.73(g), and 0 The standards ind this section are a reference by the Federal Register	§482.15(h), LTC at CAHs §485.625(g):] corporated by reference in pproved for incorporation by Director of the Office of the in accordance with 5 U.S.C. R part 51. You may obtain					

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Event ID:

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155106	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		NSTRUCTION	(X3) DATE SURVEY COMPLETED 09/28/2022	
	PROVIDER OR SUPPLIEI	₹		STREET ADDRESS, CITY, STATE, ZIP COD 295 WESTFIELD RD NOBLESVILLE, IN 46060			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG		R LSC IDENTIFYING INFORMATION the sources listed below.	-	TAG	DEFICIENCY)		DATE
	You may inspect	a copy at the CMS					
		urce Center, 7500 Security					
		ore, MD or at the National ords Administration					
		mation on the availability of					
	this material at NA	ARA, call 202-741-6030, or					
	go to:						
		es.gov/federal_register/code ations/ibr locations.html.					
		this edition of the Code are					
		eference, CMS will publish a					
document in the Federal Register to							
	announce the changes.						
		Protection Association, 1					
	Batterymarch Par Quincy, MA 0216						
	1.617.770.3000.	o, www.mpa.org,					
		th Care Facilities Code,					
		ed August 11, 2011.					
	` '	im amendment (TIA) 12-2 to					
	NFPA 99, issued	-					
	(III) 11A 12-3 to Ni 2012.	FPA 99, issued August 9,					
		FPA 99, issued March 7,					
	2013.	·					
	(v) TIA 12-5 to NF 2013.	FPA 99, issued August 1,					
	(vi) TIA 12-6 to NI 2014.	FPA 99, issued March 3,					
	(vii) NFPA 101, Li	fe Safety Code, 2012					
	edition, issued Au	•					
	11, 2011.	IFPA 101, issued August					
	(ix) TIA 12-2 to NI 30, 2012.	FPA 101, issued October					
	(x) TIA 12-3 to NF 22, 2013.	FPA 101, issued October					
		FPA 101, issued October					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDII	NG <u></u>		COMPLETED
		155106	B. WING			09/28/2022
			STI	REET ADDRESS, CITY, ST	ATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIEF	R		5 WESTFIELD RD		
RIVERW	ALK VILLAGE		NO	DBLESVILLE, IN 460	060	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S	PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREF	IX (EACH CORRECTI CROSS-REFERENC	IVE ACTION SHOULD BE CED TO THE APPROPRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TA	G DE	FICIENCY)	DATE
		Standard for Emergency and				
		ystems, 2010 edition,				
	_	chapter 7, issued August 6,				
	2009	view and interview, the facility	E 0041	\A/lagt aggregati	ive estion(s) will	10/21/2022
		t the emergency power system	E 0041		ive action(s) will hed for those	10/21/2022
	_	and maintenance requirements		·	nd to have been	
		Care Facilities Code, NFPA		affected by th		
		y Code in accordance with 42		practice?	ie delicient	
	· ·	This deficient practice could		1 ⁻	enance Director w	_{ill}
	affect all occupants	-			centage of load	
	•			tested	on the generator	
	Findings include:			monthly.	Ü	
	-			1	identify other	
	Based on records re	eview and interview with the		residents hav	ing the potential	
	Maintenance Super	visor on 09/28/22 between 9:45		to be affected	l by the same	
		., no documentation was		deficient prac	ctice and what	
		v to show the available		corrective act	tion will be taken'	?
		placed upon the generator			idents have the	
		d tests. Based on an interview		I '	affected by this	
		d review, the Maintenance		deficient pract		
	_	e was unaware that he needed			laintenance	
	_	a record of the percentage of ne generator during the			contact Evapor in	
	monthly load tests.	0		regard to generator load	recording monthly	′
	monthly load tests.			1 ~	es will be put into	
	This finding was ac	cknowledged by the		place or what	-	
	_	visor at the time of		changes you	-	
	_	ain at the exit conference with		ensure that th		
		pervisor and Executive		practice does		
	Director present at	-			/laintenance	
				Supervisor wil	ll record the	
				percentage of	load tested on	
				the Generator	monthly in the	
				TELS system.		
					ective action (s)	
					ored to ensure the	9
				deficient prac		
				recur, i.e., wh		
				assurance pro	ogram will be put	

10/20/2022 PRINTED:

	T OF HEALTH AND HUN R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155106	ľ í	JILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/28/2022	
	PROVIDER OR SUPPLIER			295 WI	ADDRESS, CITY, STATE, ZIP COD ESTFIELD RD ESVILLE, IN 46060		
(X4) ID PREFIX TAG	SUMMARY (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)	ATE	(X5) COMPLETION DATE
K 0000					into place? 'The Life Safety POC QAPI will be utilized by Maintenance Director/designee weekly x 4 weeks, monthly x 6 months, a quarterly thereafter for one yewith results reported to the Quassurance and Performance Improvement Committee over by the Executive Director 'If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	e and ear uality rseen	
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 09/28 Facility Number: 0 Provider Number: 100 At this Life Safety of was found not in co for Participation in Subpart 483.90(a), 1 2012 Edition of the Association (NFPA)	00044 155106	K 0	000	The creation and submission this Plan of Correction does n constitute an admission by thi provider of any conclusion set in the statement of deficiencie of any violation of regulation. This provider respectfully requitate the 2567 Plan of Correctibe considered the Letter of Credible Allegation and reque Desk Review on or after Octo 21, 2022.	ot is t forth es, or uests on	

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This one-story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system

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STATEMENT 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
		155106	B. W	ING		09/28/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				STFIELD RD		
RIVERW	ALK VILLAGE				SVILLE, IN 46060		
(X4) ID	SUMMARY	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
		on in the corridors and in all					
	*	rridor. The facility has					
		oke detectors in all resident					
		e facility has a capacity of 169					
	and had a census of	118 at the time of this survey.					
	All areas where the	residents have customary					
	access were sprinkle	ered. The facility has two					
	detached buildings	providing facility storage					
	services which were	e not sprinklered.					
	Quality Review con	npleted on 10/03/22					
K 0222	NFPA 101						
SS=E	Egress Doors						
Bldg. 01	Egress Doors						
ŭ	_	d means of egress shall not					
		a latch or a lock that					
		f a tool or key from the					
	-	s using one of the following					
	special locking arr	•					
		OR SECURITY THREAT					
	LOCKING						
		king arrangements for the					
		eds of the patient are					
		king device shall be					
	· ·	door and provisions shall					
		apid removal of occupants					
		of locks; keying of all					
	_	ed by staff at all times; or					
		e means available to the					
	staff at all times.						
		2.2.6, 19.2.2.2.5.1,					
	19.2.2.2.6	,,					
	SPECIAL NEEDS	LOCKING					
	ARRANGEMENTS						
		king arrangements for the					
	•	e patient are used, all of					
		curity Locking requirements					
		addition, the locks must be					

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Event ID:

 $XFOX21 \qquad {\tt Facility\ ID:} \quad 000044$

If continuation sheet

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155106		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/28/2022		
	ROVIDER OR SUPPLIER		295 WE	ADDRESS, CITY, STATE, ZIP COD ESTFIELD RD ESVILLE, IN 46060		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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	
	release upon loss building is protected automatic sprinkle space is protected detection system at an attended loc space); and both it systems are arran upon activation. 18.2.2.2.5.2, 19.2. DELAYED-EGREARRANGEMENTS Approved, listed do systems installed 7.2.1.6.1 shall be assemblies servin contents in building an approved, superdetection system automatic sprinkled 18.2.2.2.4, 19.2.2. ACCESS-CONTR LOCKING ARRAN Access-Controlled installed in accord be permitted. 18.2.2.2.4, 19.2.2. ELEVATOR LOBE LOCKING ARRAN Elevator lobby existing accordance with 7 on door assemblies throughout by an automatic fire detection automatic fire detection according to the permitted. 18.2.2.2.4, 19.2.2. 18.2.2.4, 19.2.2. 18.2.2.4, 19.2.2.	elayed-egress locking in accordance with permitted on door g low and ordinary hazard gs protected throughout by ervised automatic fire or an approved, supervised or system. 2.4 OLLED EGRESS NGEMENTS I Egress Door assemblies ance with 7.2.1.6.2 shall 2.4 BY EXIT ACCESS NGEMENTS I access door locking in 1.2.1.6.3 shall be permitted es in buildings protected approved, supervised ection system and an seed automatic sprinkler	K 0222	What corrective action(s) will	10/21/2022	
		means of egress through 5 of	K UZZZ	be accomplished for those	10/21/2022	

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Event ID:

XFOX21

Facility ID: 000044

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STREET ADDRESS, CITY, STATE, ZIP COD 255 WESTFIELD. TOD NOBLESVILLE, IN 46080 NOBLESVILLE, IN 46080 SERVET ADDRESS, CITY, STATE, ZIP COD 256 WESTFIELD. TOD NOBLESVILLE, IN 46080 SOUNDARY STATE, ZIP COD 256 WESTFIELD. TOD NOBLESVILLE, IN 46080 SOUNDARY TAG Sexists was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a lath or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 50, staff and visitors if needing to exit the facility. Findings include: Based on observation and interview during a facility turn with the Maintenance Supervisor on (9928/22 between 11.50 a.m. and 2.30 p.m., the exit doors, marked as a facility exits, were magnetically locked and could be opened by entering a four digit code but the code was either not posted or the incorrect code posted. Best control of the incorrect code posted. Best control of the incorrect code posted. Findings include: Best control of the incorrect code posted. Findings include: Best control of the incorrect code posted. Findings include: Best control of the incorrect code posted. Findings include: Best control of the incorrect code posted. Findings include: Best control to the very control of the incorrect code posted. Findings include: Best control to the very control to the incorrect code posted. Findings include to the facetility to the very control to the incorrect code posted. Findings include: Best control to the very control to the very control to the incorrect code posted. Findings include: Best control to the very control to the very control to the incorrect code posted. Findings include: Best control to the very con		IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155106	(X2) MUL A. BUII B. WIN	LDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/28/2022	
PREFIX TAO REGULATORY OR LSC IDENTIFYING INFORMATION Sexis was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Dors within a requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.5.2. This deflicient practice could affect over 50, staff and visitors if needing to exit the facility. Findings include: Based on observation and interview during a facility tour with the Maintenance Supervisor on 09/28/22 between 11.50 a.m. and 2.30 p.m., the exit doors, marked as a facility exits, were magnetically locked and could be opened by entering a four digit code but the code was either not posted or the incorrect code was posted at the exit: a) Main exit, front door - incorrect code posted. b) G-Hall exit door - incorrect code posted. c) I-Hall exit door - incorrect code posted. c) I-Ha			ER		295 WE	STFIELD RD		
TAG BEGULATORY OR SE DENTIFYEN INFORMATION 5 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Dors within a required means of egress shall not be equipped with a latch or look that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.4. Door-looking arrangements shall be permitted in accordance with 19.2.2.1.5.2. This deficient practice could affect over 50, staff and visitors if needing to exit the facility. Findings include: Based on observation and interview during a facility tour with the Maintenance Supervisor on 69/28/22 between 11:50 a.m. and 2:30 p.m., the exit doors, marked as a facility exits, were magnetically looked and could be opened by entering a four digit code but the code was either not posted or the incorrect code was posted at the exit: a) Main exit, finnt door - incorrect code posted. b) G-Hall exit door - incorrect code posted. c) K-Hall exit door - incorrect code posted. c) K-Hall exit door - incorrect code posted. c) I-Hall exit door - incorrect code p	(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
TAG RECULATORY OR ISC IDENTIFYING INFORMATION Setsits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 50, staff and visitors if needing to exit the facility. Findings include: Based on observation and interview during a facility tour with the Maintenance Supervisor on 09/28/22 between 11:50 am. and 2:30 pm., the exit doors, marked as a facility exits, were magnetically locked and could be opened by entering a four digit code but the code was either not posted or the incorrect code was posted at the exit: a) Main exit, front door - incorrect code posted. b) G-Hall exit door - incorrect code posted. c) K-Hall exit door - incorrect code posted. c) I-Hall exit door on incorrect code posted. c) I-Hall exit door - incorrect code posted. c) I-Hall exit door - incorrect c	PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	Pl	REFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
a clinical diagnosis requiring specialized security measures. Doors within a required means of egrees shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 50, staff and visitors if needing to exit the facility. Findings include: Based on observation and interview during a facility tour with the Maintenance Supervisor on 09/28/22 between 11:50 a.m. and 2:30 p.m., the exit doors, marked as a facility exits, were magnetically locked and could be opened by entering a four digit code but the code was posted at the exit: a) Main exit, front door - incorrect code posted. b) G-Hall exit door - incorrect code posted. c) I-Hall exit door - incorrect code posted. c) I-Hall exit door - incorrect code posted. e) I-Hall exit door - incorrect code posted. c) I-Hall exit door - incorrect code posted. e) I-Hall exit door - incorrect code posted. c) I-Hall exit door - incorrect code posted. e) I-Hall exit door incorrect code posted. e) I-Hall ex	TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
measures. Doors within a required means of egress shall not be equipped with a latch of lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 50, staff and visitors if needing to exit the facility. Findings include: Based on observation and interview during a facility tour with the Maintenance Supervisor on 09/28/22 between 11:50 a.m. and 2:30 p.m., the exit doors, marked as a facility exits, were magnetically locked and could be opened by entering a four digit code but the code was either not posted or the incorrect code was posted at the exit: a) Main exit, front door - incorrect code posted. b) G-Hall exit door - incorrect code posted. c) I-Hall exit door - incorrect code posted. d) J-Hall exit door - incorrect code posted. e) I-Hall exit door - incorrect code posted. e) I-Hall exit door - incorrect code posted. This finding was acknowledged by the Maintenance Supervisor at the time of observation and again at the exit conference with the Maintenance Supervisor at the time of observation and again at the exit conference with the Maintenance Supervisor and Executive Director present at 3:00 p.m. 3.1-19(b) practice? The Maintenance Director updated codes sit doors identified. The posted codes for 5/5 exit doors of lentified. The posted codes for 5/5 exit doors identified. The posted codes for 5/5 exit doors of lentified. The posted codes for 5/5 exit doors identified. The posted codes for 5/5 exit doors of lentified. The posted codes for 5/5 exit doors door lentified. The posted codes for 5/5 exit doors identified. The posted codes for 5/5 exit doors identified. The posted codes for 5/5 exit doors identified. The posted codes for 5/5 exit doors		5 exits was readily	accessible for residents without			residents found to have beer	1	
egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 50, staff and visitors if needing to exit the facility. Findings include: Based on observation and interview during a facility tour with the Maintenance Supervisor on 09/28/22 between 11:50 a.m. and 2:30 p.m., the exit doors, marked as a facility exits, were magnetically locked and could be opened by entering a four digit code but the code was either not posted or the incorrect code by the exit: a) Main exit, front door - incorrect code posted. b) G-Hall exit door - incorrect code posted. c) K-Hall exit door - incorrect code posted. d) J-Hall exit door - incorrect code posted. e) I-Hall exit door or incorrect code posted. e) I		a clinical diagnosi	s requiring specialized security			affected by the deficient		
that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 50, staff and visitors if needing to exit the facility. Findings include: Based on observation and interview during a facility tour with the Maintenance Supervisor on 09/28/22 between 11:50 a.m. and 2:30 p.m., the exit doors, marked as a facility exits, were magnetically locked and could be opened by entering a four digit code but the code was either not posted or the incorrect code was posted at the exit: a) Main exit, front door - incorrect code posted. b) G-Hall exit door - incorrect code posted. c) K-Hall exit door - incorrect code posted. d) J-Hall exit door - incorrect code posted. c) I-Hall exit door - incorrect code posted. c) I-Hall exit door - incorrect code posted. d) J-Hall exit door - incorrect code posted. c) I-Hall exit door - incorrect code posted. c) I-Hall exit door - incorrect code posted. d) J-Hall exit door - incorrect code posted. c) I-Hall exit door - incorrect code posted. c) I-Ha		measures. Doors	within a required means of			practice?		
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I will be utilized weekly x 4 weeks						will be utilized weekly x 4 weel		

PRINTED: 10/20/2022

	Γ OF HEALTH AND HU R MEDICARE & MEDIC						RM APPROVED B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155106	(X2) MULT A. BUILI B. WING	DING	otruction 01	(X3) DATE SURVEY COMPLETED 09/28/2022	
	PROVIDER OR SUPPLIE	R	2	95 WES	DRESS, CITY, STATE, ZIP COD TFIELD RD /ILLE, IN 46060		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
				tl r a C E	monthly x 6 months, and quart hereafter for one year with rese eported to the Quality Assura and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure complian	sults nce nt	
K 0232 SS=E Bldg. 01	unobstructed) ser at least 4 feet and convenient remov	Ramp Width s or corridors (clear or ving as exit access shall be a maintained to provide the val of nonambulatory patients expt as modified by ons 1-5.					
	Based on observati the clear width requested to the clear width requested and 19.2.3.4(5) states we least 8 feet, project shall be permitted all of the following	on, the facility failed to meet uirement for 1 of over 8 exception per 19.2.3.4(5). LSC where the corridor width is at ions into the required width for fixed furniture, provided that a conditions are met:	K 023	t r a r r	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient bractice? The Corridor near resident froom 207 was cleaned out. How will you identify other residents having the potentia	n nt	10/21/2022

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

feet.

of the corridor.

(b) the fixed furniture does not reduce the clear

unobstructed corridor width to less than six feet,

(c) the fixed furniture is located only on one side

(d) the fixed furniture is grouped such that each

grouping does not exceed an area of 50 square

(e) the fixed furniture groupings addressed in LSC

19.2.3.4(5) (d) are separated from each other by a

except as permitted by LSC 19.2.3.4(2).

Event ID:

XFOX21

Facility ID: 000044

items put away.

to be affected by the same

deficient practice and what

corrective action will be taken?

have the potential to be affected

by this alleged deficient practice.

Maintenance Director/designee.

All corridors observed and stored

All residents in that hallway

Facility rounds completed by

If continuation sheet

Page 9 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155106		(X2) MULTIPLE CO A. BUILDING B. WING	<u>01</u>	(X3) DATE SURVEY COMPLETED 09/28/2022	
	PROVIDER OR SUPPLIEF ALK VILLAGE	3	295 W	ADDRESS, CITY, STATE, ZIP COD ESTFIELD RD ESVILLE, IN 46060	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF distance of at least (f) the fixed furnitu obstruct access to b protection equipme (g) corridors throug are protected by an automatic smoke de with LSC 19.3.4, or arranged and locate by the facility staff space. (h) the smoke comp throughout by an ap sprinkler system in This deficient pract staff and visitors ex Findings: Based on observation facility tour with th 09/28/22 between 1 corridor near reside a bed and a lift whit Hallway. This finding was ac Maintenance Super observation and aga the Maintenance St	re is located so as to not building service and fire ont. ghout the smoke compartment electrically supervised etection system in accordance or the fixed furniture spaces are end to allow direct supervision from a nurse's station or similar coartment is protected exproved, supervised automatic accordance with LSC 19.3.5.8 dice could affect 30 residents, exiting the facility. Son and interview during a me Maintenance Supervisor on expression and 2:30 p.m., the ent room 207 contained 3 chairs, che were parked in the Corridor exhowledged by the evisor at the time of ain at the exit conference with apervisor and Executive	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? Care Companions assignments scheduled for department managers. Care Companion rounding completed daily during week. Manager on duty to round weekend to ensure corridors remain clear. Maintenance Director/designee to Environmental Rounding daily How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place? Life Safety POC QAPI Tool be utilized weekly x 4 weeks, monthly x 6 months, and quart thereafter for one year with recepted to the Quality Assurance program components.	nto ng d on the tut l will terly sults ance
	Director present at 3.1-19(b)	5.00 р.ш.		Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure complian	pe e
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from E. Discharge from E.				

Exit discharge is arranged in accordance with

						PRIN	TED: 10	1/20/2022
DEPARTMENT	OF HEALTH AND HUN	MAN SERVICES				FOF	RM APPRO	VED
ENTERS FOR	MEDICARE & MEDICA	AID SERVICES				OM	B NO. 0938	-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED	
		155106	B. WI	NG		09/28/	2022	
	PROVIDER OR SUPPLIER			295 WE	ADDRESS, CITY, STATE, ZIP COD STFIELD RD SVILLE, IN 46060	•		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5	_
PREFIX	(EACH DEFICIEN	CI MOSI DE PRECEDED BY FULL	I	PREFIX	CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLE	HON

RIVERW	ALK VILLAGE	NOBLE	NOBLESVILLE, IN 46060					
X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE				
	7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 1 of 8 exit discharges had a level walking surface, were free of obstructions, and constructed of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect 25 residents and staff using J-Hall exit. Findings include: Based on observation and interview during a facility tour with the Maintenance Supervisor on 09/28/22 between 11:50 a.m. and 2:30 p.m., the exit discharge from the J-Hall exit door, had large cracks in the concrete and was uneven immediately outside the exit door. The Maintenance Supervisor acknowledged that the walkway was in need of repair to have a complete level walking surface that was free of obstructions leading to the common way. This finding was acknowledged by the Maintenance Supervisor at the time of observation and again at the exit conference with the Maintenance Supervisor and Executive Director present at 3:00 p.m. 3.1-19(b)	K 0271	K 271 (E) Discharge from Exits What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The crack in the sidewalk outside the edit door for J Hall was repaired by the Maintenance Director/designee. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents residing on the J hall have the potential to be affected by the alleged deficient practice. All exit doors were reviewed by the Maintenance Director/designee to ensure concrete was in good repair. What measures will be put into place or what systemic changes you will make to ansure that the deficient	10/21/2022				

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ensure that the deficient practice does not recur?

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED.
		155106	B. WI	NG		09/28/	2022
	PROVIDER OR SUPPLIEI	2	STREET ADDRESS, CITY, STATE, ZIP COD 295 WESTFIELD RD NOBLESVILLE, IN 46060				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWDERIC DI ANI OF CORRECTION	-	(X5)
PREFIX	(EACH DEFICIEN	ICY 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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0293 SS=E	NFPA 101 Exit Signage				Maintenance Director/designee to review exmonthly to ensure concrete remains in good repair. Areas needing repair completed 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? Life Safety POC QAPI Tool be utilized weekly x 4 weeks, monthly x 6 months, and quarthereafter for one year with reserved to the Quality Assura and Performance Improvemer Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliant.	terly sults nce nt	
Bldg. 01	Exit Signage 2012 EXISTING Exit and direction: accordance with 7 illumination also s lighting system. 19.2.10.1 (Indicate N/A in o	al signs are displayed in 7.10 with continuous served by the emergency ne-story existing less than 30 occupants exit travel is obvious.)					
	Based on observation failed to ensure 1 of outside of the facility	on and interview, the facility f 3 courtyard doors to the ty were not mistaken as a 7.10.8.3.1 states any door,	K 02	293	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient		10/21/2022

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OMB NO. 0938-039 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 09/28/2022 155106 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 295 WESTFIELD RD NOBLESVILLE, IN 46060 RIVERWALK 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 passage, or stairway that is neither an exit nor a practice? way of exit access and that is located or arranged The "No Exit" sign was so that it is likely to be mistaken for an exit shall replaced on the door to the be identified by a sign that reads as follows: NO courtyard on Memory Care by the EXIT. The NO EXIT sign shall have the word NO Maintenance Director/designee. in letters 2 inches high, with a stroke width of All doors leading outside not 3/8ths inch, and the word EXIT below the word being used for exits were reviewed NO, unless such sign is an approved existing by the Maintenance sign. This deficient practice could affect 15 Director/designee for appropriate residents. signage. How will you identify other Findings include: residents having the potential to be affected by the same Based on observation and interview during a deficient practice and what facility tour with the Maintenance Supervisor on corrective action will be taken? 09/28/22 between 11:50 a.m. and 2:30 p.m., the All residents residing on the door into the courtyard near the Kitchenette, was Memory Care Unit have the not an exit door and the door was not posted with potential to be affected by the a "NO EXIT" sign. Based on interview at the time alleged deficient practice of the observations, the Maintenance Supervisor All doors leading outside not stated the courtyard is not an exit to the public being used for exits were reviewed way and acknowledged the courtyard door did by the Maintenance not have a "NO EXIT" sign posted and believed it Director/designee for appropriate was simply missing. signage. The "No Exit" signs to be This finding was acknowledged by the secured by Maintenance Maintenance Supervisor at the time of Director/designee. observation and again at the exit conference with What measures will be put into the Maintenance Supervisor and Executive place or what systemic Director present at 3:00 p.m. changes you will make to ensure that the deficient 3.1-19(b) practice does not recur? The "No Exit" signs will be reviewed monthly by Maintenance Director/designee to ensure they are hanging up and secured. How the corrective action (s) will be monitored to ensure the

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deficient practice will not recur, i.e., what quality

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155106	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	COMP	E SURVEY PLETED 3/2022
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CO	OD	
RIVERW	ALK VILLAGE			ESTFIELD RD ESVILLE, IN 46060		
(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 CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	RECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE
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-	are protected by a fire our fire resistance rating rated doors) or an inguishing system in 3.7.1 or 19.3.5.9. When the stic fire extinguishing system a areas shall be separated by smoke resisting 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		assurance program winto place? Life Safety POC QAI be utilized weekly x 4 wind monthly x 6 months, and thereafter for one year reported to the Quality and Performance Improcommittee overseen by Executive Director If a threshold of 95% is achieved, an action pladeveloped to ensure construction.	PI Tool will yeeks, ad quarterly with results Assurance ovement y the not n will be	
	∣ b. Laundries (large	er than 100 square feet)				

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 $XFOX21 \qquad {\tt Facility\ ID:} \quad 000044$

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		, ,				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ING	01	COMPL	
<u></u>		155106	B. WING			09/28/	2022
	PROVIDER OR SUPPLIER	2	29	STREET ADDRESS, CITY, STATE, ZIP COD 295 WESTFIELD RD NOBLESVILLE, IN 46060			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TA	AG	DEFICIENCY)		DATE
	-	nance, and Paint Shops coms (exceeding 64					
	(exceeding 64 gal	orage Rooms/Spaces					
	(over 50 square fe	-					
	,	classified as Severe					
	Hazard - see K32						
	1. Based on observation and interview, the facility		K 0321		What corrective action(s) wil	ı	10/21/2022
		f over 10 hazardous area doors,	11 0321		be accomplished for those		10/21/2022
		ms, were provided with			residents found to have beer	า	
	properly working se	elf-closing devices. This			affected by the deficient		
	deficient practice co	ould affect more than 40			practice?		
	residents, as well as	s staff and visitors.			Self-closing		
					devices/spring-loaded hinges		
	Findings include:				added to Culinary Services, R		
					135, Room 130, and Room 10	-	
		on and interview during a			Maintenance Director/designe		
	_	e Maintenance Supervisor on			· The self-closing device in	n the	
		1:50 a.m. and 2:30 p.m., the			Personals Laundry area was		
	following was noted	d:			adjusted by Maintenance		
	A) D: 4 G :				Supervisor to latch.		
		s, an area greater than 50			The Pallet of supplies wa		
	*	ed a number of combustible er, plastic, and cardboard			moved out of the G Hall dining	}	
		r door to this room was not			room.		
	equipped with a sel				How will you identify other	al	
	equipped with a ser	i-closing device.			residents having the potentia to be affected by the same	a i	
	B) Room 135 great	ter than 50 square feet, had 3			deficient practice and what		
		kes and other storage items			corrective action will be take	n?	
	·	om. The room not equipped			· All residents receiving sp		
		device or self-closing hinges.			have the potential to be affected		
					by the alleged deficient practic		
	C) Room 130, great	ter than 50 square feet, had lots			· Maintenance		
		rd boxes and other storage			Director/designee to make rou	ınds	
		the room. The room not			and review all storage areas for		
		f-closing device or self-closing			self-closing devices/spring-loa		
	hinges.	_			hinges.		
	_				Popcorn machines move	d to	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	IG <u>01</u>	COMPLETED
		155106	B. WING		09/28/2022
			CTD	FET ADDRESS CITY STATE ZID CO	- D
NAME OF I	PROVIDER OR SUPPLIEF	₹		EET ADDRESS, CITY, STATE, ZIP CO	D
	/ALIZA/III LAOF			WESTFIELD RD	
RIVERW	ALK VILLAGE		NO	BLESVILLE, IN 46060	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DDOVIDED'S DI AN OF CODDI	ection (X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFI	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	DULD BE COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAC	DEFICIENCY)	DATE
	D) Room 102, grea	ter than 50 square feet, had lots		storage areas with self-o	closing
	and lots of cardboa	rd boxes stored inside the		devices.	
	room. The room w	as not equipped with a		What measures will be	put into
		or self-closing hinges.		place or what systemic	- I
				changes you will make	
	E) The Personals Laundry Area, greater than 50			ensure that the deficien	
	square feet, had lot	s and lots of clothing and		practice does not recu	r?
	_	side the room. The room was		· Maintenance	
	equipped with a sel	f-closing device or self-closing		Director/designee review	wed all
		did not self-close and latch		storage areas for self-cl	
	into the door frame			devices/spring loaded h	-
				devices were added to a	-
	F) The G-Hall dining room, open to the corridor, contained a pallet with 40plus large boxes.			identified that required o	-
				· Activities to store p	
	_			machines in secured sto	- I
	This finding was ac	knowledged by the		when not in use.	
	Maintenance Super	- ·		How the corrective act	ion (s)
	observation and aga	ain at the exit conference with		will be monitored to en	
	the Maintenance Su	pervisor and Executive		deficient practice will r	not
	Director present at	3:00 p.m.		recur, i.e., what quality	
				assurance program wil	
	2. Based on observa	ation and interview, the facility		into place?	
	failed to maintain p	protection of 1 of 1 hot oil		·Life Safety POC QAF	PI Tool will
		the Dining Room. This		be utilized weekly x 4 w	
	deficient practice co	ould affect staff and up to 35		monthly x 6 months, and	
	residents in the mai	in dining room.		thereafter for one year v	vith results
				reported to the Quality A	
	Findings include:			and Performance Impro	
				Committee overseen by	
	Based on observation	on and interview during a		Executive Director	
	facility tour with th	e Maintenance Supervisor on		·If a threshold of 95%	is not
	09/28/22 between 1	1:50 a.m. and 2:30 p.m., a hot oil		achieved, an action plar	n will be
	popcorn popper wa	s being stored and used in the		developed to ensure co	
	Dining Room which	h was open to the corridor.			
	Based on interview	at the time of observation, the			
	Maintenance Super	visor and the Administrator			
	acknowledged the a	aforementioned condition and			
	_	prepare the popcorn in the			
		in a protected area not open to			
	the corridor.	-			

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155106	(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 09/28/2022
	PROVIDER OR SUPPLIER ALK VILLAGE		295 W	ADDRESS, CITY, STATE, ZIP COD ESTFIELD RD ESVILLE, IN 46060	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
K 0353 SS=E Bldg. 01	the Maintenance Sur Director present at 2 3.1-19(b) NFPA 101 Sprinkler System Sprinkler System Automatic sprinkler are inspected, tes accordance with Nappection, Testin Water-based Fire Records of system inspection and tes secure location are a) Date sprinkler b) Who provided c) Water system Provide in REMAR coverage for any automatic sprinkler automatic sprinkler 9.7.5, 9.7.7, 9.7.8 1. Based on observatialed to ensure sprinkler or in accordance with edition, at 5.2.1.1.1 of leakage; shall be materials, paint, and be installed in the cup-right, pendent, or	visor at the time of sin at the exit conference with spervisor and Executive 3:00 p.m. - Maintenance and Testing - Maintenance and Testing er and standpipe systems ted, and maintained in NFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, string are maintained in a and readily available. system last checked - system test - supply source - RKS information on non-required or partial er system.	K 0353	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The 4 sprinkler heads identified in Laundry were replaced. The Romex wire noted in attic above the Central Supply	the

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	LETED
		155106	B. W	ING		09/28	/2022
		1		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIEI	R			ESTFIELD RD		
RIVERW	ALK VILLAGE				ESVILLE, IN 46060		
1(1/ L1(//	TER VILLAGE			NOBEL	10 VILLE, IIV 40000		•
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		be replaced: (1) Leakage (2)			access point was		
		ical Damage (4) Loss of fluid in			secured/supported to the ceili	ing.	
	_	responsive element (5)			How will you identify other		
		ng unless painted by the			residents having the potenti	ial	
	_	urer. This deficient practice			to be affected by the same		
	could affect staff as	nd up to 6 staff.			deficient practice and what		
					corrective action will be take	en?	
	Findings include:				· All residents have the		
					potential to be affected by the	;	
	Based on observation and interview during a facility tour with the Maintenance Supervisor on				alleged deficient practice		
					· Visual Checks of Sprinkl		
	09/28/22 between 11:50 a.m. and 2:30 p.m., 4 of 4				System completed monthly by	-	
	_	he laundry area were coved in			Maintenance Director/designe	ee	
	dust or showed sign	_			and reported in TELS.		
	_	visor stated that the heads			What measures will be put in	nto	
	1	ing by the facility's sprinkler			place or what systemic		
	contractor soon.				changes you will make to		
					ensure that the deficient		
	_	cknowledged by the			practice does not recur?		
	_	visor at the time of			· Visual checks of Sprinkle		
	_	ain at the exit conference with			System completed monthly by	-	
		apervisor and Executive			Maintenance Director/designe		
	Director present at	3:00 p.m.			How the corrective action (s	-	
					will be monitored to ensure	the	
		ation and interview, the facility			deficient practice will not		
		of 1 sprinkler system in			recur, i.e., what quality		
		SC 9.7.5. LSC 9.7.5 requires all			assurance program will be p	out	
	_	systems shall be inspected			into place?		
		accordance with NFPA 25,			·Life Safety POC QAPI Too	l Will	
		spection, Testing, and			be utilized weekly x 4 weeks,		
		nter-Based Fire Protection			monthly x 6 months, and quai	-	
	1 -	5, 2011 edition, 5.2.2.2 requires			thereafter for one year with re		
		all not be subjected to external			reported to the Quality Assura		
		either resting on the pipe or			and Performance Improveme	nt	
		. This deficient practice could			Committee overseen by the		
	affect 25 residents	in one smoke compartment.			Executive Director		
					If a threshold of 95% is not		
	Findings include:				achieved, an action plan will be	oe	

Based on observation and interview during a

developed to ensure compliance

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AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155106		 UILDING	nstruction 01	(X3) DATE COMPL 09/28/	ETED	
	PROVIDER OR SUPPLIER		295 WE	DDRESS, CITY, STATE, ZIP COD STFIELD RD SVILLE, IN 46060		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
K 0363 SS=E Bldg. 01	facility tour with the 09/28/22 between 1 attic above the Cent Romex wire was dr The Maintenance S wires were being sure. This finding was ac Maintenance Super observation and agathe Maintenance Super	visor at the time of ain at the exit conference with apervisor and Executive 3:00 p.m. corridor openings in other assures of vertical openings, as areas resist the passage made of 1 3/4 inch wood or other material ag fire for at least 20 fully sprinklered smoke a only required to resist the a. Corridor doors and doors ag flammable or rials have positive latching atches are prohibited by these requirements do not spaces that do not contain	TAG	DEFICIENCY		DATE

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	01	COMPL	
		155106	B. WI	NG		09/28/	/2022
NAME OF I	PROVIDER OR SUPPLIEF	}			ADDRESS, CITY, STATE, ZIP COD		
RIVERW	ALK VILLAGE				ESTFIELD RD ESVILLE, IN 46060		
	T				T		T
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
	`				CROSS-REFERENCED TO THE APPROPRIA	ATE	
PREFIX TAG	release when the permitted. Nonrate unlimited height a meeting 19.3.6.3.1 frames shall be la other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restri resistance of glass assemblies. 19.3.6.3, 42 CFR 483, and 485 Show in REMARK fire protection ratin devices, etc. Based on observation failed to ensure 1 or impediment to closs frame and would re This deficient pract. Findings include: Based on observation facility tour with the 109/28/22 between 1 corridor door to Resand latch positively interview at the tim Maintenance Super aforementioned corridor door corridor c	fire window assemblies are a sprinklered compartments ctions in area or fire is or frames in window. Parts 403, 418, 460, 482, 483 details of doors such as angs, automatics closing in and interview, the facility if over 30 corridor doors had not ing and latching into the door sist the passage of smoke. In increase, increase of smoke in and interview during a me Maintenance Supervisor on 1:50 a.m. and 2:30 p.m., the sident Room 218 failed to close into the door frame. Based on the of the observations, the visor agreed the ridor door did not close and frame and would not resist the eknowledged by the	K 03	PREFIX TAG		II n ate was	TOMPLETION DATE
	_	ain at the exit conference with			What measures will be put in	nto	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155106		(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/28/2022	
	PROVIDER OR SUPPLIE		295	ET ADDRESS, CITY, STATE, ZIP COD WESTFIELD RD BLESVILLE, IN 46060	1
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IT CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
TAG	the Maintenance S Director present at 3.1-19(b)	R LSC IDENTIFYING INFORMATION upervisor and Executive 3:00 p.m.	TAG	place or what systemic changes you will make to ensure that the deficient practice does not recur? Maintenance Director to check for Latches and gaps quarterly and document in Thow the corrective action will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place? Life Safety POC QAPI To be utilized weekly x 4 weeks monthly x 6 months, and quathereafter for one year with reported to the Quality Assurance Program and Performance Improvem Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will developed to ensure compliants.	TELS. (s) e the put pol will s, arterly results arance aent ot
K 0511 SS=E Bldg. 01	complies with NF Code, electrical v complies with NF Code. Existing in service provided 18.5.1.1, 19.5.1.1. Based on observensure 1 of 1 electrowas maintained in 19.5.1.1 requires u	d Electric gas or related gas piping PA 54, National Fuel Gas viring and equipment PA 70, National Electric stallations can continue in no hazard to life.	K 0511	What corrective action(s) when the accomplished for those residents found to have be affected by the deficient practice?	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURV	EY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155106	B. W	NG		09/28/2022	2
				CTREET	ADDRESS SITY STATE ZIR COD		
NAME OF P	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD		
					ESTFIELD RD		
RIVERW	ALK VILLAGE			NORLE	SVILLE, IN 46060		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	CON	MPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	to comply with NF	PA 70, National Electrical Code.			· Outlet was repaired and		
	NFPA 70, 2011 Ed	ition, Article 314.28(3) (c) states			placed back in socket by		
	junction boxes shal	l be provided with covers			Maintenance Supervisor/desig	nee.	
	compatible with the	e box and suitable for the			· A lock was placed on		
	conditions of use. Where used, metal covers shall				electrical panel by room 116 b	y	
	comply with the grounding requirements of				Maintenance Supervisor.		
	250.110. This deficient practice could affect staff				How will you identify other		
	and 15 residents in	the corridor near the ice			residents having the potentia	ıl	
	machine				to be affected by the same		
					deficient practice and what		
	Findings include:				corrective action will be take	n?	
					· ALL residents have the		
	Based on observation and interview during a				potential to be affected by the		
	facility tour with the Maintenance Supervisor on				alleged deficient practice		
	09/28/22 between 11:50 a.m. and 2:30 p.m., an				· All exterior electrical pane	els	
	electrical outlet box	x behind the ice machine in the			were checked by Maintenance	:	
	corridor was not att	tached to the wall and wires			Supervisor/designee to ensure		
	were exposed from	the rear.			secured.		
					What measures will be put in	to	
	This finding was ac	cknowledged by the			place or what systemic		
	Maintenance Super	visor at the time of			changes you will make to		
	observation and aga	ain at the exit conference with			ensure that the deficient		
	the Maintenance Su	pervisor and Executive			practice does not recur?		
	Director present at	3:00 p.m.			· Electrical panels to be		
					reviewed monthly by Maintena	ince	
	2. Based on observa	ation and interview, the facility			Supervisor/designee.		
		electrical panels in the			How the corrective action (s)		
	corridors were secu	red from non-authorized			will be monitored to ensure t	he	
	1 ~	0, 2011 edition states 230.62			deficient practice will not		
	Energized parts of	service equipment shall be			recur, i.e., what quality		
	_	ed in 230.62(A) or guarded as			assurance program will be p	ut	
	specified in 230.62				into place?		
	` ′	gized parts shall be enclosed			·Life Safety POC QAPI Tool	will	
	1	t be exposed to accidental			be utilized weekly x 4 weeks,		
		guarded as in 230.62(B).			monthly x 6 months, and quar	erly	
	` '	gized parts that are not enclosed			thereafter for one year with res	sults	
		n a switchboard, panelboard, or			reported to the Quality Assura	nce	
	_	guarded in accordance with			and Performance Improvemer	ıt	
		Where energized parts are			Committee overseen by the		
	guarded as provide	d in 110.27(A)(1) and (A)(2), a			Executive Director		

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	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 B. WING			(X3) DATE SURVEY COMPLETED 09/28/2022			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 295 WESTFIELD RD NOBLESVILLE, IN 46060				
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	means for locking o access to energized	or sealing doors providing parts shall be provided. This ould affect 26 all staff and			·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliant	ved, an action plan will be	
	facility tour with the 09/28/22 between 1 electrical panel near unlocked when tested						
		nin at the exit conference with approximate specific pervisor and Executive 3:00 p.m.					
K 0712 SS=C Bldg. 01	alarm signal and s conditions. Fire dr and unexpected ti conditions, at leas The staff is familia aware that drills at routine. Where dr 9:00 PM and 6:00	ay be used instead of					
		view and interview, the facility	K 0'	712	What corrective action(s) will be accomplished for those		10/21/2022

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· /		ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED				
		155106	B. W	ING		09/28/2	2022
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 295 WESTFIELD RD NOBLESVILLE, IN 46060				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDEDS 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	тс	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	iie	DATE
	unexpected days an	d at unexpected times under			residents found to have beer	n	
		This deficient practice could			affected by the deficient		
	affect all residents,	staff and visitors in the facility.			practice?		
	affect all residents, Findings include: Based on records re Documentation regainterview with the M 09/28/22 between 9 quarterly fire drills the month, between conditions do not all at unexpected times stated that it just get the month. This finding was ac Maintenance Superobservation and againtenance and superobservation and againtenance supe	eview of the "Logbook arding Fire Drills - TELS" and Maintenance Supervisor on :45 a.m. and 11:50 a.m., 9 of were conducted near the end of the 26th and 30th day. These low fire drills to be conducted in the Maintenance Supervisor to overlooked until the end of the Maintenance Supervisor at the time of the time of the time of the exit conference with pervisor and Executive			practice? How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take All residents have the potential to be affected by the alleged deficient practice Fire drills to be scheduled and completed on unexpected days and times under varying conditions. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? Education provided to Maintenance Director regarding fire drills and scheduling. Fire drills to be scheduled throughout the month and completed on unexpected day and varying times. 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? Life Safety POC QAPI Tool be utilized weekly x 4 weeks, monthly x 6 months, and quarthereafter for one year with residents.	d d d to ng d the ut will terly sults	
					monthly x 6 months, and quar	-	
			1		reported to the Quality Assura and Performance Improvemer		
			1		Lana i chomiance implovemen	IL.	

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CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155106		(X2) MULTIP A. BUILDIN B. WING	LE CONSTRUCTION IG 01	(X3) DATE SURVEY COMPLETED 09/28/2022		
	PROVIDER OR SUPPLIEI /ALK VILLAGE	R	29	EET ADDRESS, CITY, STATE, ZIP C 5 WESTFIELD RD BLESVILLE, IN 46060	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREF TAG	CROSS-REFERENCED TO THE A	RRECTION (X5) HOULD BE APPROPRIATE COMPLETION DATE	
				Committee overseen be Executive Director If a threshold of 95% achieved, an action play developed to ensure committee.	% is not an will be	
K 0754 SS=E Bldg. 01	shall not exceed average density of room or space ship gallons/square feed capacity of 32 gall within any 64 square linen or trash collection of trash collection or t	Trash Containers sh collection receptacles 32 gallons in capacity. The of container capacity in a all not exceed 0.5 et. A total container lons shall not be exceeded are feet area. Mobile soiled ection receptacles with r than 32 gallons shall be protected as a hazardous ended. solely for recycling are scluded from the above ere each container is less 6 gallons unless attended, r combustibles are labeled eting FM Approval Standard int.				
	Based on observati failed to ensure 2 of the corridor did not within a 64 square practice could affect in the smoke comp Findings include:	on and interview, the facility f 2 soiled linen receptacles in exceed 32 gallons in capacity foot area. This deficient et staff and up to 20 residents	K 0754	What corrective action be accomplished for the residents found to hat affected by the deficient practice? Soiled barrels we soiled Utility room for the How will you identify residents having the to be affected by the second process.	those eve been ent ere moved to storage. other potential	

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facility tour with the Maintenance Supervisor on

09/28/22 between 11:50 a.m. and 2:30 p.m., there

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deficient practice and what

corrective action will be taken?

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155106	(X2) MULTIPI A. BUILDIN B. WING	le construction ag <u>01</u>	(X3) DATE SURVEY COMPLETED 09/28/2022
	ROVIDER OR SUPPLIER ALK VILLAGE		295	EET ADDRESS, CITY, STATE, ZIP COE 5 WESTFIELD RD BLESVILLE, IN 46060	
(X4) ID PREFIX TAG	SUMMARY SECRET SUMMARY SECRET SET SUMMARY SECRET SECRET SECRET SECRET SUMMARY SECRET SUMMARY SECRET SUMMARY SECRET SUMMARY SUMMARY SECRET SUMMARY SUMARY SUMMARY SUMMARY SUMMARY SUMMARY SUMMARY SUMMARY SUMMARY SUMARY SUMMARY SUMMARY SUMMARY SUMMARY SUMMARY SUMMARY SUMARY SUMMARY	knowledged by the visor at the time of in at the exit conference with pervisor and Executive	ID PREFIT TAG	PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPLEADED THE APPLEAD	completion DATE COMPLETION DATE DATE COMPLETION DATE
K 0918 SS=C Bldg. 01	Electrical Systems System Maintenar The generator or source and associ of supplying service	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power ated equipment is capable the within 10 seconds. If the		Executive Director If a threshold of 95% is achieved, an action plan developed to ensure com	will be

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STATEMEN	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DA		(X3) DATE	SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETE			ETED	
		155106	B. WI	NG		09/28/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER				ESTFIELD RD			
RIVERWALK VILLAGE				SVILLE, IN 46060			
1000	T						
(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)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	, , ,	ocess shall be provided to					
	I	his capability for the life					
	1	branches. Maintenance					
	_	generator and transfer					
	1	ormed in accordance with					
	NFPA 110.	a imama ata duna aldu					
		e inspected weekly,					
		oad 30 minutes 12 times a					
		intervals, and exercised onths for 4 continuous hours.					
		nder load conditions include					
		ated cold start and					
	· ·	ual transfer of all EES					
		nducted by competent					
		enance and testing of stored					
		rces (Type 3 EES) are in					
		NFPA 111. Main and feeder					
		re inspected annually, and a					
		dically exercising the					
		tablished according to					
		uirements. Written records					
		nd testing are maintained					
		ble. EES electrical panels					
	1	arked, readily identifiable,					
	and separate from	n normal power circuits.					
	Minimizing the po	ssibility of damage of the					
	emergency power	source is a design					
	consideration for	new installations.					
	6.4.4, 6.5.4, 6.6.4	(NFPA 99), NFPA 110,					
	NFPA 111, 700.10	0 (NFPA 70)					
	Based on record rev	view and interview, the facility	K 09	918	What corrective action(s) wil	I	10/21/2022
		e generator for 12 of 12 months			be accomplished for those		
	-	ments of NFPA 110, 2010			residents found to have beer	า	
		rd for Emergency and Standby			affected by the deficient		
	•	Chapter 6.4.4.1.1.4(a) of 2012			practice?		
	_	monthly testing of the			Maintenance Director will	l	
		ne emergency electrical system			record the percentage of load	_	
		with NFPA 110, Chapter 8.			tested on the generator month	ıly.	
		8.4.2 states diesel generator			How will you identify other		
	sets in service shall	be exercised at least once			residents having the potentia	al	

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPI	LETED
		155106	B. WING		09/28	/2022
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF 1	PROVIDER OR SUPPLIEF	R		ESTFIELD RD		
RIVFRW	ALK VILLAGE			ESVILLE, IN 46060		
1017 = 1007	T			1		T
(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 APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	· ·	mum of 30 minutes, using one		to be affected by the same		
	of the following me			deficient practice and what		
		nintains the minimum exhaust		corrective action will be take	n?	
		recommended by the		· All residents have the		
	manufacturer			potential to be affected by this	i	
		temperature conditions and at		deficient practice.		
	•	cent of the EPS (Emergency		· The Maintenance Superv	/isor	
	Power Supply) nam	-		to contact Evapor in regard to		
		es diesel-powered EPS		recording monthly generator lo	oad	
		not meet the requirements of		testing.		
		ised monthly with the available				
	, , ,	Power Supply System) load and		What measures will be put in	ito	
		nnually with supplemental		place or what systemic		
		n 50 percent of the EPS		changes you will make to		
	_	g for 30 continuous minutes		ensure that the deficient		
		75 percent of the EPS		practice does not recur?		
	-	g for 1 continuous hour for a		· The Maintenance Superv		
		f not less than 1.5 continuous		will record the percentage of lo		
	_	.2 of NFPA 99 requires a		tested on the Generator month	hly	
		spection, performance,		in the TELS system.		
		and repairs for the generator to		How the corrective action (s)		
		ined and available for		will be monitored to ensure t	:he	
		athority having jurisdiction.		deficient practice will not		
	This deficient pract	ice could affect all occupants.		recur, i.e., what quality		
	l			assurance program will be p	ut	
	Findings include:			into place?		
				·The Life Safety POC QAPI		
		eview and interview with the		will be utilized by Maintenance	9	
		visor on 09/28/22 between 9:45		Director/designee weekly x 4		
		, no documentation was		weeks, monthly x 6 months, a		
		to show the available		quarterly thereafter for one year		
		placed upon the generator		with results reported to the Qu	ıality	
		d tests. Based on an interview		Assurance and Performance		
		d review, the Maintenance		Improvement Committee over	seen	
	-	e was unaware that he needed		by the Executive Director		
	_	a record of the percentage of		If a threshold of 95% is not		
		e generator during the		achieved, an action plan will b		
	monthly load tests.			developed to ensure complian	ice	

This finding was acknowledged by the

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155106	(X2) MULTIPLE (A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 09/28/2022
	PROVIDER OR SUPPLIER		295 W	ADDRESS, CITY, STATE, ZIP COD ESTFIELD RD ESVILLE, IN 46060	
(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
	_	in at the exit conference with pervisor and Executive			
K 0920 SS=E Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemb assembled by qua the conditions of 1 the patient care vi non-PCREE (e.g., except in long-terr do not use PCREI meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care re other UL standard used with general cords are not used wiring of a structur temporarily are re completion of the installed and mee: 10.2.3.6 (NFPA 98) (NFPA 70), 590.3	de electrical equipment les that have been alified personnel and meet 0.2.3.6. Power strips in cinity may not be used for personal electronics), in care resident rooms that E. Power strips for PCREE out 60601-1. Power strips the patient care rooms meet UL 1363. In coms, power strips meet s. All power strips are precautions. Extension d as a substitute for fixed re. Extension cords used moved immediately upon purpose for which it was ts the conditions of 10.2.4. d), 10.2.4 (NFPA 99), 400-8 (D) (NFPA 70), TIA 12-5			
	failed to ensure 2 of as a substitute for fi equipment with a hi	tion and interview, the facility 2 power strips were not used xed wiring to provide power gh current draw. 0.8 state unless specifically	K 0920	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	

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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>			COMPL	ETED
		155106	B. WI	B. WING		09/28/2022	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	3			STFIELD RD		
RIVERW	ALK VILLAGE				SVILLE, IN 46060		
	Г	CTATEMENT OF DEFICIENCIE	1		· 		(VE)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1710		flexible cords and cables shall	1	1/10	· The power strip in		DAIL
	*	as a substitute for fixed wiring.			Conference Room was secure	ed by	
	` ′	ice could affect up to 3			Maintenance Director.	.a by	
	residents.	1			· Power strips with approp	riate	
					label were ordered and will be		
	Findings include:				placed in Resident Room 223,	ı	
					239, 120, 202, and 210 upon		
		on and interview during a			arrival.		
	1	e Maintenance Supervisor on			How will you identify other		
		1:50 a.m. and 2:30 p.m., in			residents having the potentia	al	
		20 and (2) Resident Room 223 a			to be affected by the same		
	1 -	ing used to power a dorm style			deficient practice and what		
	refrigerator (high p	ower draw equipment).			corrective action will be take	n?	
	TE1 ' C' 1'	1 1 1 11 1			· All residents have the		
		cknowledged by the			potential to be affected by this		
	Maintenance Super	ain at the exit conference with			deficient practice.	ماد	
	_	ann at the exit conference with appervisor and Executive			 Care Companions will ch their resident rooms to ensure 		
	Director present at	-			appropriate power strips are in		
	Director present at	5.00 p.m.			use.	'	
	2. Based on observa	ation and interview, the facility			acc.		
		f 1 flexible cords were installed			What measures will be put in	ito	
	properly and used in	n a safe manor. NFPA 99,			place or what systemic		
	Section 10.2.4.2 sta	ntes adapters and extension			changes you will make to		
	cords meeting the r	equirements of 10.2.4.2.1			ensure that the deficient		
	_	shall be permitted. Section			practice does not recur?		
		e cabling shall comply with			· Care Companions will ch	eck	
		2.3.5.1 states cord strain relief			their resident rooms to ensure		
	_	t the attachment of the power			appropriate power strips are ir	1	
		ce so that mechanical stress,			use.		
	_	r bend, is not transmitted to			The correctly labeled pov		
		s. This deficient practice could 13 staff and residents in the			strips will be provided as need	ea	
	conference room.	13 Statt and residents in the			in resident rooms. How the corrective action (s)		
	conference room.				will be monitored to ensure t		
	Findings include:				deficient practice will not	116	
	i mamgo menae.				recur, i.e., what quality		
	Based on observation	on and interview during a			assurance program will be p	ut	
		e Maintenance Supervisor on			into place?		
	1	1:50 a.m. and 2:30 p.m., in (1)			·The Life Safety POC QAPI	Tool	
	1	1 / (/	1				

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155106	(X2) MULT A. BUILD B. WING	DING	nstruction 01	(X3) DATE COMPL 09/28 /	ETED	
	ROVIDER OR SUPPLIEF		2	95 WE	DDRESS, CITY, STATE, ZIP COD STFIELD RD SVILLE, IN 46060			
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIENT REGULATORY OF conference room and power strip was being and was not secured condition could put causing damage to the Maintenance Sustrip was dangling, power strip will need floor. This finding was act Maintenance Superfloor. This finding was act Maintenance Superfloor. This finding was act Maintenance Superfloor. 3. Based on observation and against the Maintenance Superfloor present at 2. 3. Based on observation of 1363 A vicinity is defined a intended for the exampatients, extending location of the bed, device that supports examination and treextends vertically to floor. This deficient Findings include: Based on observation floor observation floor of the sexual floor of the floor	at the time of observations, apervisor agreed the power not secured, and stated the ed to be mounted or set on the knowledged by the visor at the time of ain at the exit conference with apervisor and Executive 3:00 p.m. ation and interview, the facility wer strips in all locations met at or 60601-1. Patient care as a space, within a location amination and treatment of a feet beyond the normal chair, table, treadmill, or other as the patient during seatment. A patient care vicinity of 7 feet 6 inches above the at practice affects 12 resident. On and interview during a e Maintenance Supervisor on 1:50 a.m. and 2:30 p.m., the rips lacked a label with the 1363A or 60601-1 on each	I PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) will be utilized by Maintenance Director/designee weekly x 4 weeks, monthly x 6 months, at quarterly thereafter for one yea with results reported to the Qu Assurance and Performance Improvement Committee overs by the Executive Director If a threshold of 95% is not achieved, an action plan will b developed to ensure complian	e nd ar ality seen	(X5) COMPLETION DATE	

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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	ILDING	01	COMPL	
		155106	B. WI	B. WING 09/28/2023		/2022	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					ESTFIELD RD		
RIVERW	ALK VILLAGE			NOBLE	SVILLE, IN 46060		
(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 APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	b) Resident Roonc) Resident Roon						
	d) Resident Room						
	e) Resident Roon						
	e) resident result	1210					
	This finding was ac	knowledged by the					
	Maintenance Superv						
	observation and aga	in at the exit conference with					
	the Maintenance Su	pervisor and Executive					
	Director present at 3	3:00 p.m.					
	3.1-19(b)						
K 0923	NFPA 101						
SS=E		Cylinder and Container					
Bldg. 01	Storag	-					
	•	Cylinder and Container					
	Storage						
	Greater than or ec	ual to 3,000 cubic feet					
	Storage locations	are designed, constructed,					
	and ventilated in a	ccordance with 5.1.3.3.2					
	and 5.1.3.3.3.						
	>300 but <3,000 c						
	Storage locations						
		n an enclosed interior					
	•	mited- combustible					
		door (or gates outdoors)					
		ed. Oxidizing gases are not					
		ables, and are separated					
		by 20 feet (5 feet if					
		closed in a cabinet of					
		onstruction having a					
	Less than or equa	re protection rating.					
	-	compartment, individual					
	_	for immediate use in					
	-	with an aggregate volume					
		ial to 300 cubic feet are not					
		red in an enclosure.					
	-	handled with precautions					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED			ETED	
		155106	B. WING 09/28/2022			2022	
		OTDEET ADDRESS STAY OT ATE THE COD					
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
RIVERWALK VILLAGE							
RIVERVV	ALK VILLAGE			NOBLE	SVILLE, IN 46060		
(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 APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	as specified in 11.	.6.2.					
	A precautionary si	ign readable from 5 feet is					
	on each door or g	ate of a cylinder storage					
	room, where the s	sign includes the wording as					
	a minimum "CAU	ΓΙΟΝ: OXIDIZING GAS(ES)					
	STORED WITHIN	I NO SMOKING."					
	Storage is planne	d so cylinders are used in					
	order of which the	y are received from the					
	supplier. Empty of	ylinders are segregated					
	from full cylinders	. When facility employs					
	cylinders with inte	gral pressure gauge, a					
	threshold pressure	e considered empty is					
	established. Emp	ty cylinders are marked to					
	avoid confusion. (Cylinders stored in the open					
	are protected from	n weather.					
	11.3.1, 11.3.2, 11	.3.3, 11.3.4, 11.6.5 (NFPA					
	99)						
	Based on observation	on and interview, the facility	K 0	923	What corrective action(s) will	I	10/14/2022
	failed to ensure 3 of	f 4 cylinders of nonflammable			be accomplished for those		
		en were properly secured from			residents found to have beer	1	
	-	Health Care Facilities Code,			affected by the deficient		
		on 11.3.2 states storage for			practice?		
		s greater than 8.5 cubic meters			 The four oxygen cylinders 	S	
		less than 85 cubic meters			were removed from the reside	nt	
		nall comply with 11.3.2.1			room and placed in container i	in	
	-	NFPA 99, Section 11.3.2.6 states			Oxygen Storage Room.		
	1 -	er restraints shall comply with			How will you identify other		
		1.6.2.3(11) states freestanding			residents having the potentia	al	
		roperly chained or supported			to be affected by the same		
		stand or cart. This deficient			deficient practice and what		
	practice could affect	et 2 residents.			corrective action will be take	n?	
					· All residents have the		
	Findings include:				potential to be affected by this		
					deficient practice.		
		on and interview during a			· Hospice Services notified	d of	
	1	e Maintenance Supervisor on			proper storage of Oxygen.		
		1:50 a.m. and 2:30 p.m., 3 of 4 'E'			What measures will be put in	ito	
	, , , , ,	ers were standing upright on			place or what systemic		
		t room 223 and were not			changes you will make to		
	properly chained or	supported in a proper cylinder			ensure that the deficient		

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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	01	COMPLETED	
		155106	B. WING	.=	09/28/2022
			OTD FEE	T ADDRESS SITE STATE SID SOF	
NAME OF F	PROVIDER OR SUPPLIE	₹		T ADDRESS, CITY, STATE, ZIP COD VESTFIELD RD	
DI\/ED\//	ALK VILLAGE			ESVILLE, IN 46060	
I XI V LI XVV					
(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	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		oxygen cylinders was secured		practice does not recur?	
		23. Based on interview at the		· Hospice notified of	
		, the Maintenance Supervisor		appropriate oxygen storage.	
	_	'E' type oxygen cylinders were		· Care Companions/MOD	to
		proper cylinder stand or cart		check rooms daily to ensure	
	and should not be s	tored in a resident room.		Oxygen stored appropriately.	
				How the corrective action (s	5)
	_	knowledged by the		will be monitored to ensure	the
	Maintenance Super			deficient practice will not	
		ain at the exit conference with		recur, i.e., what quality	
		pervisor and Executive		assurance program will be p	out
	Director present at	3:00 p.m.		into place?	
				·The Life Safety POC QAPI	
	3.1-19(b)			will be utilized by Maintenanc	e
				Director/designee weekly x 4	
				weeks, monthly x 6 months, a	and
				quarterly thereafter for one ye	ear
				with results reported to the Q	uality
				Assurance and Performance	
				Improvement Committee over	rseen
				by the Executive Director	
				·If a threshold of 95% is not	t
				achieved, an action plan will b	be
				developed to ensure complian	nce

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