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	06/17/2024

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: 06/17/24 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 107. Quality Review completed on 06/24/24	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: 06/17/24 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	07/12/2024

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	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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 a capacity for 141 residents and had a census of 107 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 06/24/24			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be			

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	155121	A. BUILDING 01 B. WING	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION ST LAFAYETTE, IN 47904

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	permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall			

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	155121	A. BUILDING 01 B. WING	06/17/2024

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ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION ST LAFAYETTE, IN 47904

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	be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 8 exits were 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 as many as 14 residents, 8 staff, and 2 visitors in the facility. Findings include: Based on observations made with the Maintenance Supervisor during a tour of the facility at 1:35 a.m. on 06/17/24, the exit door nearest to the Business Office was clearly marked as a facility exit, was magnetically locked and could be opened by entering a four-digit code but the code was not posted at the exit. Based on interview at the time of the observations, the Maintenance Supervisor stated the aforementioned facility exit was indeed marked as exit and could be opened by entering a four-digit code, but the correct code was not posted.	K 0222	**K 222 Egress Doors** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The four digit exit code was immediately posted at the identified exit door. **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:** 14 residents, 8 staff and 2 visitor have the potential to be affected by deficient finding. All exit doors were audited to ensure the door code is posted and visible at each door. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:**	07/23/2024

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	155121	A. BUILDING 01 B. WING	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION ST LAFAYETTE, IN 47904

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	This item was again discussed at the exit conference held on 06/17/24 at 2:17 p.m. 3.1-19(b)		Maintenance staff will be in-serviced on posting door codes at each exit door on or before 7/23/24. Maintenance or designee will continue to observe exit doors to ensure door codes are posted 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: 7/23/24	
K 0225 SS=F Bldg. 01	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used			

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	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 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 in the facility. Findings include: Based on observations made with the Maintenance Supervisor during a tour of the facility between 11:30 a.m. and 2:06 p.m. on 06/17/24, all four of the four exit stairwells did 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 of the 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. This item was again discussed at the exit conference held on 06/17/24 at 2:17 p.m. 3.1-19(b)	K 0225	**K- 255 Stairways and Smokeproof Enclosures** **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 7/10/24. **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 7/10/24. **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 7/10/24, which indicates the facility met the level of LSC equivalent to the prescribed NFPA 101, LSC for Health Care Occupancy.	07/10/2024

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K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____		**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:** FSES was completed on 7/10/24, which indicates the facility met the level of LSC equivalent to the prescribed NFPA 101, LSC for Health Care Occupancy. ED will ensure FSES is conducted annually **By what date the systemic changes for each deficiency will be completed:** **Compliance date:** 7/10/24	

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	155121	A. BUILDING 01 B. WING	06/17/2024

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	Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 16 of over 100 sprinkler heads in the facility were clean, free of foreign materials, and corrosion. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect as many as 14 residents, 8 staff, and 2 visitors in the facility. Findings include: Based on observations made with the Maintenance Supervisor during a tour of the facility between 11:30 a.m. and 2:06 p.m. on 06/17/24, the following was noted: A) Paint was found on the sidewall sprinkler heads in the following Resident rooms: 1) Resident room #101. #102, #103, #105, #107, #141, #143 B) Paint was found on the upright sprinkler heads in the following Resident rooms: 2) Resident room #104, #106, #108, #109, #125, #129, #135, #136, #139, and #144. Based on an interview at the time of each observation, the Maintenance Supervisor stated that the resident rooms had been recently painted, but he was not aware of all the paint the painters got on the numerous sprinkler heads located	K 0353	**K 353- Sprinkler System-Maintenance and Testing** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The 16 identified sprinkler heads were immediately replaced. **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:** 14 residents, 8 staff and 2 visitor have the potential to be affected by deficient finding. A facility audit will be conducted to ensure that all sprinkler heads are clean and free from debris or paint. Any sprinkler heads identified from this audit will be replaced. **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 Maintenance of Sprinkler Heads on or before 7/23/24. Maintenance or designee will continue to observe sprinkler heads to ensure they are clean	07/23/2024

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	throughout the facility. This item was again discussed at the exit conference held on 06/17/24 at 2:17 p.m. 3.1-19(b)		and free of debris 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: 7/23/24	
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: 06/17/24	K 0000		

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	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 a capacity for 141 residents and had a census of 107 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 06/24/24			