STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155106	A. BUILDING -- B. WING	10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVERWALK VILLAGE	295 WESTFIELD RD 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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/30/23 Facility Number: 000044 Provider Number: 155106 AIM Number: 100274940 At this Emergency Preparedness survey, Riverwalk Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 169 certified beds. At the time of the survey, the census was 123. Quality Review completed on 11/02/23	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/30/23 Facility Number: 000044 Provider Number: 155106 AIM Number: 100274940 At this Life Safety Code survey, Riverwalk Village was found not in compliance with Requirements	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
keith davis	Senior Executive Director	11/16/2023

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

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	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 one-story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 169 and had a census of 123 at the time of this survey. All areas where the residents have customary access were sprinklered. The facility has two detached buildings providing facility storage services which were not sprinklered. Quality Review completed on 11/02/23			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of over 8 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 20 residents, staff and visitors if	K 0211	K 211 We respectfully request desk review in this matter. Thank you for your consideration. What corrective action(s) will be	11/16/2023

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	needing to exit the facility. Findings include: Based on observations and interview during a tour of the facility with the Acting Maintenance Director and Field Maintenance Supervisor on 10/30/23 between 11:50 a.m. and 2:45 p.m., the egress corridor near resident room #214 contained 24 boxes where were being stored on both sides of the corridor. The ED stated that the boxes contained glove racks which are intended to be installed in the resident rooms. The path of egress was marked as a facility exit with an exit sign. Based on interview at the time of the observations, the Acting Maintenance Director agreed the aforementioned means of egress was not continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This finding was acknowledged at the time of discovery by the Acting Maintenance Director, Field Maintenance Supervisor and Executive Director and again at the exit conference with the Acting Maintenance Director, Field Maintenance Supervisor and Executive Director all present. 3.1-19(b)		accomplished for those residents found to have been affected by the deficient practice; - no residents were affected by this alleged deficient practice - boxes have been removed from corridor How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; - all residents have the same potential to be affected by this alleged deficient practice - boxes in question in corridor have been removed from corridor - Maintenance personnel were educated on 11/13/23 by the Senior Executive Director on maintaining means of egress (See attachment 1) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; - Maintenance personnel was educated on 11/13/23 by the Senior Executive Director on maintaining means of egress (See attachment 1) - appropriate corrections were made by immediately removing boxes in question - Maintenance to conduct audit to ensure compliance (See attachment A) How the corrective action(s) will be	

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			monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; • Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. • CQI tool identified as means of egress (See attachment A) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. • If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; • Completion date: 11/16/23	
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 permitted on each door and provisions shall be made for the rapid removal of occupants			

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	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 be permitted. 18.2.2.2.4, 19.2.2.2.4			

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	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 the J-Hall exit 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 15 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations and interview during a tour of the facility with the Acting Maintenance Director and Field Maintenance Supervisor on 10/30/23 between 11:50 a.m. and 2:45 p.m., the J-Hall exit door, marked as a facility exit, was magnetically locked and could be opened by entering a four-digit code but the code was not posted by the keypad. The Acting Maintenance Director stated that the code was likely removed during some recent painting and just not put back next to the keypad. This finding was acknowledged at the time of discovery by the Acting Maintenance Director, Field Maintenance Supervisor and Executive	K 0222	K 222 We respectfully request desk review in this matter. Thank you for your consideration. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; • No residents were affected by this alleged deficient practice - the door code has been posted by the keypad How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; • All residents have the same potential to be affected by this alleged deficient practice - the door code has been posted by the keypad - Maintenance personnel have been educated on 11/13/23 on means of egress and displaying of door codes (see attachment 1)	11/16/2023

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	Director and again at the exit conference with the Acting Maintenance Director, Field Maintenance Supervisor and Executive Director all present. 3.1-19(b)		. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; • Door/keypad code has been corrected with code posted - Maintenance personnel was educated on 11/13/23 on means of egress and displaying of door codes (see attachment 1) - Maintenance to conduct audit to ensure compliance (see attachment A) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; • Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. • CQI tool identified as Means of egress/door codes (see attachment A) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. • If Threshold of 100% is not met, an action plan will be developed to ensure compliance.	

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			By what date the systemic changes will be completed; • Completion date: 11/16/23	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 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 over 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. Findings include: Based on observations and interview during a tour of the facility with the Acting Maintenance Director and Field Maintenance Supervisor on 10/30/23 between 11:50 a.m. and 2:45 p.m., the exit discharge near resident room 201 was obstructed with 3 large wooden pallets which were leaning against the fence immediately outside the exit door. This finding was acknowledged at the time of discovery by the Acting Maintenance Director, Field Maintenance Supervisor and Executive Director and again at the exit conference with the Acting Maintenance Director, Field Maintenance	K 0271	K 271 We respectfully request desk review in this matter. Thank you for your consideration. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; • No residents were affected by this alleged deficient practice - wooden pallets were removed from fence outside 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; • All residents have the same potential to be affected by this alleged deficient practice - the wooden pallets were removed from	11/16/2023

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	Supervisor and Executive Director all present. 3.1-19(b)		fence outside exit door - Maintenance personnel have been educated on 11/13/23 exits remaining free from obstruction (see attachment 1) . What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; • Wooden pallets were removed from fence outside exit door - Maintenance personnel was educated on 11/13/23 on exits remaining free from obstruction (see attachment 1) - Maintenance to conduct audit to ensure compliance (see attachment A) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; • Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. • CQI tool identified as Means of exits free from obstruction (see attachment A) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter	

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			until compliance is achieved. • If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; • Completion date: 11/16/23	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 1. Based on record review, interview, and observation, the facility failed to ensure documentation for the preventative maintenance of all battery-operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include:	K 0300	K 300 We respectfully request desk review in this matter. Thank you for your consideration. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; • No residents/staff were affected by this alleged deficient practice - all battery operated smoke alarms have a date identifying when installed or when batteries changed. – lp tank connected to a gas grill was removed from the staff smoking area	11/16/2023

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	Based on records review and interview on 1030/23 between 9:30 a.m. and 11:45 a.m. with the Acting Maintenance Director, Field Maintenance Supervisor and Executive Director, no completed itemized list for preventative maintenance and specifically battery replacement of resident room battery operated smoke alarms was available for review. During the facility tour battery operated smoke detectors were observed in each resident room. The aforementioned smoke alarms had stickers which are intended to record the date of installation and battery replacement, however the stickers were blank and no other documentation was available to indicate when the units were installed or when batteries were changed. This finding was acknowledged at the time of discovery by the Acting Maintenance Director, Field Maintenance Supervisor and Executive Director and again at the exit conference with the Acting Maintenance Director, Field Maintenance Supervisor and Executive Director all present. 2. Based on interview, and observation, the facility failed to ensure propane tanks were stored properly away from all ignition sources. NFPA 58 specifies storage requirements including required separation distances for LP gas containers. This deficient practice could affect 4 staff. Findings include: Based on observations and interview during a tour of the facility with the Acting Maintenance Director and Field Maintenance Supervisor on 10/30/23 between 11:50 a.m. and 2:45 p.m., in the smoking area a LP propane tank was being stored and was connected to a gas grill.		How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; • All residents/staff have the same potential to be affected by this alleged deficient practice - all battery operated smoke alarms have a date identifying when installed or when batteries were changed - lp tank connected to a gas grill was removed from the staff smoking area - Maintenance personnel have been educated on 11/13/23 by the Senior Executive Director on battery operated smoke alarm documentation and lp/propane tank storage (see attachment 1) . What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; • All battery operated smoke alarms have a date identifying when installed or when batteries were changed - lp tank connected to a gas grill was removed from the staff smoking area - Maintenance personnel were educated on 11/13/23 by the Senior Executive Director on	

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	This finding was acknowledged at the time of discovery by the Acting Maintenance Director, Field Maintenance Supervisor and Executive Director and again at the exit conference with the Acting Maintenance Director, Field Maintenance Supervisor and Executive Director all present. 3.1-19(b)		battery operated smoke alarm documentation and lp tank storage (see attachment 1) - Maintenance to conduct audit to ensure compliance (see attachment A) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; • Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. • CQI tool identified as battery operated smoke alarm documentation/lptank storage (see attachment A) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. • If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; • Completion date: 11/16/23	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of			

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	Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2			
	Based on observation and interview, the facility failed to install the kitchen range hood system in accordance with the requirements of LSC 9.2.3. Section 9.2.3 states commercial cooking equipment shall be installed in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 2011 edition, Section 6.2.4.1 states kitchen range hood system filters shall be equipped with a drip tray beneath their lower edges. The tray shall be kept to the minimum size needed to collect grease and shall be pitched to drain into an enclosed metal container having a capacity not exceeding 1 gal (3.785 L). This deficient practice could affect up to 6 staff and visitors. Findings include: Based on observations and interview during a tour of the facility with the Acting Maintenance	K 0324	K 324 We respectfully request desk review in this matter. Thank you for your consideration. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; • No residents/staff were affected by this alleged deficient practice - The kitchen hood drip pan installation is scheduled for repair on or before 11/30/23 (See attachment B) 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;	11/30/2023

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVERWALK VILLAGE	295 WESTFIELD RD 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
	Director and Field Maintenance Supervisor on 10/30/23 between 11:50 a.m. and 2:45 p.m., the design of the kitchen hood did not appear to provide for the collection of grease from the kitchen hood. Grease was dripping down from the hood and onto the floor behind and on the appliance. The Acting Maintenance Director agreed and stated that the grease was not being captured in any drip tray. Kitchen staff stated that it had always been this way. The surveyor and the Acting Maintenance Director could not determine if parts were missing to the system to meet the requirement of collecting the grease in a drip tray, but clearly no drip tray was present as the grease was dripping down from the range hood system at the time of the survey. The most recent record of a thorough hood cleaning from the facility's vendor was dated 10/4/23 and close to the time of the survey. This finding was acknowledged at the time of discovery by the Acting Maintenance Director, Field Maintenance Supervisor and Executive Director and again at the exit conference with the Acting Maintenance Director, Field Maintenance Supervisor and Executive Director all present. 3.1-19(b)		• All residents/staff have the same potential to be affected by this alleged deficient practice - The kitchen hood drip pan installation is scheduled on or before 11/30/23 (see attachment B). Maintenance personnel have been educated on 11/13/23 by the Senior Executive Director on kitchen drip pan operations (see attachment 1) . What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; • The kitchen drip pan hood installation is scheduled for installation on or before 11/30/23. (see attachment B) - Maintenance personnel were educated on 11/13/23 by the Senior Executive Director on operations of kitchen hood drip pan (see attachment 1) - Maintenance to conduct audit to ensure compliance (see attachment A) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; • Ongoing compliance with this corrective action will be monitored	

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			via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. • CQI tool identified as kitchen hood drip pan functional (see attachment A) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. • If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; • Completion date: 11/30/23	
K 0353 SS=F 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 _____ 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			

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	Based on record review and interview, the facility failed to maintain 1 of 1 automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on records review and interview on 1030/23 between 9:30 a.m. and 11:45 a.m. with the Acting Maintenance Director, Field Maintenance Supervisor and Executive Director, the provided documentation regarding the facility's sprinkler system, under the deficiencies summary section of the reports dated 08/8/2022 and 05/2/2023 several of the same deficiencies were listed and didn't appear to have been corrected. Following conversations with the main office and the vendor, no documentation was provided to show the listed deficiencies had been corrected. This finding was acknowledged at the time of discovery by the Acting Maintenance Director, Field Maintenance Supervisor and Executive	K 0353	K 353 We respectfully request desk review in this matter. Thank you for your consideration. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; • No residents/staff were affected by this alleged deficient practice - all deficiencies with our sprinkler system in question have been corrected How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; • All residents/staff have the same potential to be affected by this alleged deficient practice - all deficiencies with our sprinkler system in question have been corrected.- Maintenance personnel have been educated on 11/13/23 by the Senior Executive Director on facility sprinkler system (see attachment 1) . What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;	11/16/2023

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	Director and again at the exit conference with the Acting Maintenance Director, Field Maintenance Supervisor and Executive Director all present. 3.1-19(b)		• All deficiencies with our sprinkler system in question have been corrected. - Maintenance personnel were educated on 11/13/23 by the Senior Executive Director on facility sprinkler system (see attachment 1) - Maintenance to conduct audit to ensure compliance (see attachment A) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; • Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. • CQI tool identified as sprinkler system operational (see attachment A) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. • If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; • Completion date: 11/16/23	
K 0355 SS=E	NFPA 101 Portable Fire Extinguishers			

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Bldg. 01	Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers in the Data room were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (3) In a cabinet or wall recess. This deficient practice was not in a resident care area but could affect 3 staff in the Data Room. Findings include: Based on observations and interview during a tour of the facility with the Acting Maintenance Director and Field Maintenance Supervisor on 10/30/23 between 11:50 a.m. and 2:45 p.m., an ABC portable fire extinguisher in the Data Room was sitting on a A/C ledge and was unsecured. Based on interview at the time of observation, the Acting Maintenance Director agreed the extinguisher was sitting unsupported. This finding was acknowledged at the time of discovery by the Acting Maintenance Director, Field Maintenance Supervisor and Executive Director and again at the exit conference with the Acting Maintenance Director, Field Maintenance Supervisor and Executive Director all present.	K 0355	K 355 We respectfully request desk review in this matter. Thank you for your consideration. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; • No residents/staff were affected by this alleged deficient practice - fire extinguisher secured in appropriate manner How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; • All residents/staff have the same potential to be affected by this alleged deficient practice - fire extinguisher in question secured in appropriate manner - Maintenance personnel have been educated on 11/13/23 by the Senior Executive Director on fire extinguisher installation (see attachment 1) .	11/16/2023

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	3.1-19(b)		What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; • Fire extinguisher in question secured in appropriate manner - Maintenance personnel were educated on 11/13/23 by the Senior Executive Director on fire extinguisher installation (see attachment 1) - Maintenance to conduct audit to ensure compliance (see attachment A) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; • Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. • CQI tool identified as fire extinguisher installation (see attachment A) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. • If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic	

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			changes will be completed; Completion date: 11/16/23	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window			

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	assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure all corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 6 staff and 15 residents. Findings include: Based on observations and interview during a tour of the facility with the Acting Maintenance Director and Field Maintenance Supervisor on 10/30/23 between 11:50 a.m. and 2:45 p.m., the following corridor doors failed to latch positively into their respective door frames: a) Kitchen double door set leading into the dining room - this door was also missing a coordinator which would allow the double doors to close in a specific order. b) The double door set near Resident Room #216 c) The double door set near Resident Room #126 This finding was acknowledged at the time of discovery by the Acting Maintenance Director, Field Maintenance Supervisor and Executive Director and again at the exit conference with the Acting Maintenance Director, Field Maintenance Supervisor and Executive Director all present. 3.1-19(b)	K 0363	K 363 We respectfully request desk review in this matter. Thank you for your consideration. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; • No residents/staff were affected by this alleged deficient practice - double door sets in question were all corrected and all latch positively How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; • All residents/staff have the same potential to be affected by this alleged deficient practice - double door sets in question were all corrected and all latch positively - Maintenance personnel have been educated on 11/13/23 by the Senior Executive Director on corridor doors latching positively (see attachment 1)	11/16/2023

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			.	

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;

• All double doors in question have been corrected and all latch positively - Maintenance personnel were educated on 11/13/23 by the Senior Executive Director on corridor doors latching positively (see attachment 1) - Maintenance to conduct audit to ensure compliance (see attachment A)

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;
• Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director.
• CQI tool identified as corridor doors latching positively (see attachment A) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved.
• If Threshold of 100% is not met, an action plan will be developed to ensure compliance.

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			By what date the systemic changes will be completed; • Completion date: 11/16/23	
K 0754 SS=E Bldg. 01	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 Based on observation and interview, the facility failed to ensure 2 of 2 soiled linen receptacles in the corridor did not exceed 32 gallons in capacity within a 64 square foot area. This deficient practice could affect staff and up to 15 residents in the smoke compartment. Findings include: Based on observations and interview during a tour of the facility with the Acting Maintenance Director and Field Maintenance Supervisor on 10/30/23 between 11:50 a.m. and 2:45 p.m., there	K 0754	K 754 We respectfully request desk review in this matter. Thank you for your consideration. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; • No residents/staff were affected by this alleged deficient practice - Soiled linen carts were removed	11/16/2023

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	were 2 large 33-gallon soiled linen carts in the corridor near resident room 110. Based on interview at the time of observation, the Acting Maintenance Director stated that they belong in the closet across the hall from where the carts were being stored. This finding was acknowledged at the time of discovery by the Acting Maintenance Director, Field Maintenance Supervisor and Executive Director and again at the exit conference with the Acting Maintenance Director, Field Maintenance Supervisor and Executive Director all present. 3.1-19(b)		from the corridor How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; • All residents/staff have the same potential to be affected by this alleged deficient practice - soiled linen carts were removed from the corridor- Maintenance personnel have been educated on 11/13/23 by the Senior Executive Director on soiled linen cart storage (see attachment 1) . What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; • Soiled linen carts were removed from the corridor - Maintenance personnel were educated on 11/13/23 by the Senior Executive Director on soiled linen cart storage (see attachment 1) - Maintenance to conduct audit to ensure compliance (see attachment A) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into	

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			place; • Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. • CQI tool identified as soiled linen carts stored appropriately (see attachment A) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. • If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; • Completion date: 11/16/23	
K 0781 SS=E Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on observation and interview, the facility failure to ensure 1 of 1 portable space heaters were not used in the facility. This deficient practice could affect up to 3 staff. Findings include: Based on observations and interview during a	K 0781	K 781 What corrective action(s) will be accomplished for those residents/staff found to have been affected by the deficient practice;	11/16/2023

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	tour of the facility with the Acting Maintenance Director and Field Maintenance Supervisor on 10/30/23 between 11:50 a.m. and 2:45 p.m., a portable space heater was in use in the Data Room. Based on interview at the time of the observations, the Field Maintenance Supervisor agreed a space heater was being used and had recently been unplugged as the unit was still extremely hot to the touch. The Acting Maintenance Director and Field Maintenance Supervisor each stated that the facility's policy is not to use portable space heaters in any area of the building and that they are not allowed. A written policy was not provided during the survey, however the Acting Maintenance Director, Field Maintenance Supervisor and Executive Director each confirmed during the record review period that portable space heaters are not permitted anywhere at the facility. This finding was acknowledged at the time of discovery by the Acting Maintenance Director, Field Maintenance Supervisor and Executive Director and again at the exit conference with the Acting Maintenance Director, Field Maintenance Supervisor and Executive Director all present. 3.1-19(b)		• No residents/staff were affected by this alleged deficient practice - The space heater in question was removed from the data room and from the property How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; • All residents/staff have the same potential to be affected by this alleged deficient practice - space heater in question was removed from the data room and from the property - Maintenance personnel have been educated on 11/13/23 by the Senior Executive Director on space heater usage (see attachment 1) . What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; • Space heater in question was removed from the data room and removed from the property - Maintenance personnel were educated on 11/13/23 by the Senior Executive Director on space heater usage (see attachment 1) - Maintenance to conduct audit to ensure	

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			compliance (see attachment A) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; • Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. • CQI tool identified as no space heater usage in facility (see attachment A) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. • If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; • Completion date: 11/16/23	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155106	A. BUILDING 01 B. WING	10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVERWALK VILLAGE	295 WESTFIELD RD NOBLESVILLE, IN 46060

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	the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 2 staff in the maintenance office. Findings include: Based on observations and interview during a tour of the facility with the Acting Maintenance Director and Field Maintenance Supervisor on 10/30/23 between 11:50 a.m. and 2:45 p.m., in the maintenance shop office area, a ceiling light was being powered by a green extension cord. Based on interview at the time of observation, the Acting Maintenance Director acknowledged an extension cord was in use as described above. This finding was acknowledged at the time of discovery by the Acting Maintenance Director,	K 0920	K 920 We respectfully request desk review in this matter. Thank you for your consideration. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; • No residents/staff were affected by this alleged deficient practice - extension cord in question removed and replaced with appropriate power cord How other residents/staff having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; • All residents/staff have the same potential to be affected by this	11/16/2023

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	Field Maintenance Supervisor and Executive Director and again at the exit conference with the Acting Maintenance Director, Field Maintenance Supervisor and Executive Director all present. 3.1-19(b)		alleged deficient practice - extension cord in question has been removed and replaced with appropriate power cord - Maintenance personnel have been educated on 11/13/23 by the Senior Executive Director on appropriate power cord usage (see attachment 1) . What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; • power cord removed and replaced with appropriate power cord - Maintenance personnel was educated on 11/13/23 by the Senior Executive Director on proper power cord usage (see attachment 1) - Maintenance to conduct audit to ensure compliance (see attachment A) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; • Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director.	

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			• CQI tool identified as appropriate power cord usage (see attachment A) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. • If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; • Completion date: 11/16/23	