keith davis

PRINTED: 11/20/2023 FORM APPROVED OMB NO. 0938-039

11/16/2023

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155106		A. Bl	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  10/30/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 295 WESTFIELD RD NOBLESVILLE, IN 46060				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION
TAG E 0000	REGULATORY OR	LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCE		DATE
Bldg	conducted by the In	paredness Survey was diana Department of Health in	E 0	000			
	accordance with 42 Survey Date: 10/30	)/23					
	Facility Number: 0 Provider Number: 1	155106					
	Riverwalk Village v Emergency Prepare	Preparedness survey, was found in compliance with dness Requirements for caid Participating Providers FR 483.73					
	the survey, the cens						
K 0000	Quality Review con	npleted on 11/02/23					
Bldg. 01	Licensure Survey w	Recertification and State as conducted by the Indiana th in accordance with 42 CFR	K 0	0000			
	Survey Date: 10/30	1/23					
	Facility Number: 0 Provider Number: 1002	155106					
		Code survey, Riverwalk Village mpliance with Requirements					
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATUR	Е	TITLE		(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 disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Senior Executive Director

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039			
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155106	A. BUILDING B. WING	01	COMPLETED 10/30/2023			
NAME OF PROVIDER OR SUPPLIER RIVERWALK VILLAGE			295 WI	STREET ADDRESS, CITY, STATE, ZIP COD  295 WESTFIELD RD  NOBLESVILLE, IN 46060				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	I	(X5)			
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION			
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE			
K 0211 SS=E Bldg. 01	for Participation in Subpart 483.90(a), 2012 Edition of the Association (NFPA Chapter 19, Existin 410 IAC 16.2.  This one-story facil Type V (111) const sprinklered. The fawith smoke detection areas open to the conduction of the existence of th	Medicare/Medicaid, 42 CFR Life Safety from Fire and the National Fire Protection ) 101, Life Safety Code (LSC), g Health Care Occupancies and  ity was determined to be of ruction and was fully cility has a fire alarm system on in the corridors and in all bridor. The facility has toke detectors in all resident the facility has a capacity of 169 control of this survey.  residents have customary tered. The facility has two providing facility storage te not sprinklered.  mpleted on 11/02/23  - General	K 0211	K 211 We respectfully request desk	11/16/2023			
	or impediments to f	full instant use in the case of		review in this matter. Thank yo	ou			
	fire or other emerge	ency. This deficient practice		for your consideration.				
	could affect over 20	residents, staff and visitors if		What corrective action(s) will b	е			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155106		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY  COMPLETED  10/30/2023		
	PROVIDER OR SUPPLIEF	2	295 WE	ADDRESS, CITY, STATE, ZIP COD ESTFIELD RD ESVILLE, IN 46060		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF needing to exit the second of the facility of the facility of the corridor near 24 boxes where we of the corridor. The contained glove racinstalled in the resident of the path of egress with an exit sign.  Based on interview observations, the A agreed the aforement of continuously mobstructions or impute case of fire or of the corridor of the case of fire or of the case of the case of fire or of the case of the c	ons and interview during a with the Acting Maintenance Maintenance Supervisor on 1:50 a.m. and 2:45 p.m., the resident room #214 contained re being stored on both sides ED stated that the boxes ks which are intended to be dent rooms.  was marked as a facility exit  at the time of the cting Maintenance Director ntioned means of egress was aintained free of all ediments to full instant use in			nts y the ents e e ntial (See	(X5) COMPLETION DATE
				question - Maintenance to con audit to ensure compliance (S attachment A)	nduct	

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How the corrective action(s) will be

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155106	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 10/30/2023	
	PROVIDER OR SUPPLIER	2	STREET ADDRESS, CITY, STATE, ZIP COD 295 WESTFIELD RD NOBLESVILLE, IN 46060			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				monitored to ensure the defici- practice will not recur, what qu assurance program will be put place; • Ongoing compliance with this corrective action will be monitor via facility QAPI program, with meetings being held monthly, is overseen by the Executive Director. • CQI tool identified as means egress (See attachment A) wil completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. • If Threshold of 100% is not in an action plan will be develope ensure compliance.  By what date the systemic changes will be completed; • Completion date: 11/16/23	ality t into s pred and of ll be	
K 0222 SS=E Bldg. 01	be equipped with requires the use of egress side unless special locking arr CLINICAL NEEDS LOCKING Where special lockinical security needs	and means of egress shall not a latch or a lock that of a tool or key from the susing one of the following rangements:  SOR SECURITY THREAT thing arrangements for the seeds of the patient are sking device shall be				

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permitted on each door and provisions shall be made for the rapid removal of occupants

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155106		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 01	COMPL	(X3) DATE SURVEY COMPLETED 10/30/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 295 WESTFIELD RD NOBLESVILLE, IN 46060				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECEACH CORRECTIVE ACTION SHOW	ULD BE	(X5) COMPLETION	
TAG	``	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	PROPRIATE	DATE	
	by: remote control	of locks; keying of all					
		ed by staff at all times; or					
		e 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	S					
	· ·	king arrangements for the					
		e patient are used, all of					
		curity Locking requirements					
	•	addition, the locks must be					
		at fail safely so as to					
	•	of power to the device; the					
		ed by a supervised					
		r system and the locked					
		by a complete smoke					
	-	(or is constantly monitored					
		ation within the locked					
		he sprinkler and detection					
	· ·	ged to unlock the doors					
	upon activation.	2252 TIA 42 4					
	18.2.2.2.5.2, 19.2.						
	DELAYED-EGRES						
	ARRANGEMENTS						
		elayed-egress locking in accordance with					
	7.2.1.6.1 shall be						
		g low and ordinary hazard					
		gs protected throughout by					
		ervised automatic fire					
		or an approved, supervised					
	automatic sprinkle						
	18.2.2.2.4, 19.2.2.	•					
	ACCESS-CONTR						
	LOCKING ARRAN						
		I Egress Door assemblies					
		ance with 7.2.1.6.2 shall					
	be permitted.						
	18.2.2.2.4, 19.2.2.	2.4					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION (X3) DATI			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING 01 COMPLETE			ETED
		155106	B. WING 10/30/2023			/2023	
NAME OF E	PROVIDER OR SUPPLIER		_	STREET A	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	ì ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION  ELEVATOR LOBBY EXIT ACCESS			TAG			DATE
	LOCKING ARRAN						
		t access door locking in					
	I	7.2.1.6.3 shall be permitted					
		es in buildings protected					
		approved, supervised					
	automatic fire dete	ection system and an					
	approved, supervi	sed automatic sprinkler					
	system.						
	18.2.2.2.4, 19.2.2						
		on and interview, the facility	K 0	222	K 222		11/16/2023
	failed to ensure the means of egress through the						
		lily accessible for residents			We respectfully request desk		
		iagnosis requiring specialized			review in this matter. Thank yo	ou	
		Doors within a required means			for your consideration.	L -	
	_	be equipped with a latch or ne use of a tool or key from the			What corrective action(s) will l		
	_	therwise permitted by LSC			accomplished for those reside		
	_	ocking arrangements shall be			found to have been affected b deficient practice;	y trie	
		ance with 19.2.2.2.5.2. This			dencient practice,		
	1 ~	ould affect over 15 residents,			No residents were affected be	nv.	
	_	needing to exit the facility.			this alleged deficient practice	у	
	Starr and Visitors in	needing to exit the facility.			- the door code has been pos	sted	
	Findings include:				by the keypad	otou	
					How other residents having th	ie	
	Based on observation	ons and interview during a			potential to be affected by the		
		with the Acting Maintenance			same deficient practice will be		
	Director and Field I	Maintenance Supervisor on			identified and what corrective		
	10/30/23 between 1	1:50 a.m. and 2:45 p.m., the			action(s) will be taken;		
	J-Hall exit door, ma	arked as a facility exit, was					
		d and could be opened by			All residents have the same		
		t code but the code was not			potential to be affected by this		
		nd. The Acting Maintenance			alleged deficient practice - the		
		the code was likely removed			door code has been posted by		
	_	painting and just not put back			keypad - Maintenance person		
	next to the keypad.				have been educated on 11/13	3/23	
	TE1 ' C' 1'	1 11 1 (1 2 2			on means of egress and		
	_	knowledged at the time of			displaying of door codes (see		
	1	cting Maintenance Director, Supervisor and Executive			attachment 1)		
	1 Teta ivialitienance	Supervisor and Executive			Ī		I

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155106		(X2) MULTIPLE A. BUILDING B. WING	O1	(X3) DATE SURVEY  COMPLETED  10/30/2023					
	PROVIDER OR SUPPLIEI	₹	295 V	STREET ADDRESS, CITY, STATE, ZIP COD 295 WESTFIELD RD NOBLESVILLE, IN 46060					
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF Director and again Acting Maintenance	STATEMENT OF DEFICIENCIE SCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION at the exit conference with the e Director, Field Maintenance ecutive Director all present.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	nto nges the ecur; en - s eans of or dit to this nitored with y, and e ens of eted times reafter d. t met,				

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CENTERS FO	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION (X	3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED 10/30/2023	
		155106	B. WING			
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	R		ESTFIELD RD		
RIVERW	ALK VILLAGE			ESVILLE, IN 46060		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	,	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE	
				By what date the systemic		
				changes will be completed;		
				Completion date: 11/16/23		
K 0271	NFPA 101					
SS=E	Discharge from E	vite				
Bldg. 01	Discharge from E					
Diag. 01	_	arranged in accordance with				
	_	vel walking surface meeting				
	•	7.1.7 with respect to				
	·	ion and shall be maintained				
	_	ns. Additionally, the exit				
		e a hard packed all-weather				
	travel surface.	a nara paonos an mounto.				
	18.2.7, 19.2.7					
		on and interview, the facility	K 0271	K 271	11/16/2023	
		f over 8 exit discharges had a	10271		11/10/2025	
		ce, were free of obstructions,		We respectfully request desk		
	_	hard packed all-weather travel		review in this matter. Thank you		
		ice with CMS Survey and		for your consideration.		
		05-38. This deficient practice		What corrective action(s) will be		
	could affect 25 resi	dents.		accomplished for those residents	II	
				found to have been affected by t	II	
	Findings include:			deficient practice;		
	Based on observation	ons and interview during a		No residents were affected by		
		with the Acting Maintenance		this alleged deficient practice		
		Maintenance Supervisor on		- wooden pallets were removed	ı	
		1:50 a.m. and 2:45 p.m., the exit		from fence outside exit door		
		dent room 201 was obstructed		How other residents having the		
		n pallets which were leaning		potential to be affected by the		
		nmediately outside the exit		same deficient practice will be		
	door.	-		identified and what corrective		
				action(s) will be taken;		
	This finding was ac	knowledged at the time of		, , , , , , , , , , , , , , , , , , , ,		
		cting Maintenance Director	1	• All residents have the same		

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Field Maintenance Supervisor and Executive

Director and again at the exit conference with the

Acting Maintenance Director, Field Maintenance

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potential to be affected by this

alleged deficient practice - the

wooden pallets were removed from

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155106		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 10/30/2023			
		STREET ADDRESS, CITY, STATE, ZIP COD 295 WESTFIELD RD						
LK VILLAGE			NOBLE	SVILLE, IN 46060				
SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREI			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
Supervisor and Execusion 3.1-19(b)	cutive Director all present.			educated on 11/13/23 exits				
				place or what systemic chang will be made to ensure that the	es e			
				from fence outside exit door - Maintenance personnel was educated on 11/13/23 on exits remaining free from obstructio (see attachment 1) - Maintena to conduct audit to ensure	s n nnce			
				monitored to ensure the defici practice will not recur, what quassurance program will be put place;  • Ongoing compliance with this corrective action will be monitovia facility QAPI program, with meetings being held monthly, is overseen by the Executive Director.  • CQI tool identified as Means exits free from obstruction (se attachment A) will be complete.	ent uality t into s ored and of e ed			
	OVIDER OR SUPPLIER  LK VILLAGE  SUMMARY:  (EACH DEFICIEN  REGULATORY OR  Supervisor and Exe	IDENTIFICATION NUMBER 155106  OVIDER OR SUPPLIER  LK VILLAGE  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  Supervisor and Executive Director all present.	TOURISM OF CORRECTION IDENTIFICATION NUMBER 155106  A. BU B. W. OVIDER OR SUPPLIER  LK VILLAGE  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  Supervisor and Executive Director all present.	F CORRECTION IDENTIFICATION NUMBER  155106  OVIDER OR SUPPLIER  LK VILLAGE  SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION  Supervisor and Executive Director all present.	OVIDER OR SUPPLIER LK VILLAGE  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  Supervisor and Executive Director all present.  3.1-19(b)  What measures will be put intiplace or what systemic change will be made to ensure that the deficient practice does not rec  - Wooden pallets were remove from fence outside exit door - Maintenance personnel have educated on 11/13/23 exits remaining free from obstructic (see attachment 1)  - What measures will be put intiplace or what systemic change will be made to ensure that the deficient practice does not rec  - Wooden pallets were remove from fence outside exit door - Maintenance personnel was educated on 11/13/23 on exits remaining free from obstructic (see attachment 1)  How the corrective action(s) we monitored to ensure the deficient practice will not recur, what quasurance program will be put place;  - Ongoing compliance with this corrective action (see attachment 4.  How the corrective action will be monitored to ensure the deficient practice will not recur, what quasurance program will be put place;  - Ongoing compliance with this corrective action will be monitored to ensure the deficient practice will not recur, what quasurance program will be put place;  - Ongoing compliance with this corrective action will be monitored to ensure the deficient practice will not recur, what quasurance program will be put place;  - Ongoing compliance with this corrective action will be monitored to ensure the deficient practice will not recur, what quasurance program will be put place;  - Ongoing compliance with this corrective action will be monitored to ensure the deficient practice will not recur, what quasurance program will be put into place will not recur, what quasurance program will be put into place will not recur, what quasurance program will be put into place will not recur, what quasurance program will be put into place will not recur, what quasurance program will be put into place will not recur, wh	FORRECTION  DENTIFICATION NUMBER 155106  A. BUILDING B. WINC  STREET ADDRESS, CITY, STATE, ZIP COD 295 WESTFIELD RD NOBLESVILLE, IN 46060  SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 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;  *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)  Whooden 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)  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;  Oncompliance (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		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 01			COMPLETED	
		155106	B. WING 10/30/2023			/2023		
	PROVIDER OR SUPPLIEI ALK VILLAGE	R		295 WE	ADDRESS, CITY, STATE, ZIP COD ESTFIELD RD ESVILLE, 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	.TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					until compliance is achieved.  • If Threshold of 100% is not n an action plan will be developed ensure compliance.  By what date the systemic changes will be completed;  • Completion date: 11/16/23			
K 0300 SS=F Bldg. 01	Section 18.3 and requirements that provided K-tags, I information, along Safety Code or N should be include 1. Based on record observation, the fact documentation for of all battery-opera rooms was complet existing life safety if not required by the NFPA 72, 29.10 M Fire-warning equip tested in accordance published instruction of Chapter 14. NFF testing, and mainted the requirements of equipment manufact	r RKS section any LSC	K 03	300	K 300  We respectfully request desk review in this matter. Thank you for your consideration.  What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice;  • No residents/staff were affected by this alleged deficient practicall battery operated smoke alled have a date identifying when installed or when batteries changed.  — Ip tank connected to a gas gowas removed from the staff smoking area	oe ents y the eted ce - arms	11/16/2023	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			î ´		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED				
		155106	B. W	ING		10/30/2023	
NAME OF I	DROVIDED OD CUDDI IEI			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	<b>C</b>			ESTFIELD RD		
RIVERW	ALK VILLAGE			NOBLE	SVILLE, IN 46060		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION	1
TAG		R LSC IDENTIFYING INFORMATION	_	TAG			
		eview and interview on 1030/23 and 11:45 a.m. with the Acting			How other residents having the	•	
		tor, Field Maintenance			potential to be affected by the same deficient practice will be		
		cutive Director, no completed			identified and what corrective		
	_	ventative maintenance and			action(s) will be taken;		
	_	replacement of resident room			assorito, mil so takon,		
		oke alarms was available for			All residents/staff have the s	ame	
		facility tour battery operated			potential to be affected by this		
		re observed in each resident			alleged deficient practice - all		
	room. The aforement	ntioned smoke alarms had			battery operated smoke alarm	s	
		ntended to record the date of			have a date identifying when		
	installation and battery replacement, however the				installed or when batteries we	re	
	stickers were blank and no other documentation				changed	-	
		licate when the units were			lp tank connected to a gas gri	I	
	installed or when ba	atteries were changed.			was removed from the staff		
					smoking area - Maintenance		
	_	knowledged at the time of			personnel have been educate		
		eting Maintenance Director,			11/13/23 by the Senior Execu	tive	
		Supervisor and Executive			Director on battery operated		
		at the exit conference with the			smoke alarm documentation a	ind	
		e Director, Field Maintenance		lp/propane tank storage (see			
	Supervisor and Exe	cutive Director all present.			attachment 1)		
		ew, and observation, the					
	_	sure propane tanks were stored					
		all ignition sources. NFPA 58			What measures will be put into		
		quirements including required			place or what systemic chang	•	
		s for LP gas containers. This			will be made to ensure that the		
	deficient practice co	ould affect 4 staff.			deficient practice does not rec	ur;	
	Findings include:				All battery operated smoke		
					alarms have a date identifying		
	Based on observation	ons and interview during a			when installed or when batteri	es	
	tour of the facility v	with the Acting Maintenance			were changed - lp tank conne		
		Maintenance Supervisor on			to a gas grill was removed from	m	
		1:50 a.m. and 2:45 p.m., in the			the staff smoking area -		
		propane tank was being stored			Maintenance personnel were		
	and was connected	to a gas grill.			educated on 11/13/23 by the		
	l				Senior Executive Director on	ĺ	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C	onstruction 01	(X3) DATE SURVEY  COMPLETED		
		155106	B. WING		10/30/2023	
	PROVIDER OR SUPPLIE	R	295 W	STREET ADDRESS, CITY, STATE, ZIP COD 295 WESTFIELD RD NOBLESVILLE, IN 46060		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
TAG	This finding was a discovery by the A Field Maintenance Director and again Acting Maintenance	cknowledged at the time of acting Maintenance Director, Supervisor and Executive at the exit conference with the ace Director, Field Maintenance ecutive Director all present.	TAG	battery operated smoke alarm documentation and lp tank sto (see attachment 1) - Maintent to conduct audit to ensure compliance (see attachment 1).  How the corrective action(s) monitored to ensure the deficiency practice will not recur, what quassurance program will be puplace;  Ongoing compliance with the corrective action will be monivia facility QAPI program, with meetings being held monthly, is overseen by the Executive Director.  CQI tool identified as battery operated smoke alarm documentation/lptank storage attachment A) will be compleweekly x 4 weeks, monthly tin 6 months, and quarterly there until compliance is achieved.  If Threshold of 100% is not an action plan will be developensure compliance.	n prage ance  A)  will be ient uality at into is tored in and  y  e (see ted ines eafter imet,	
K 0324	NFPA 101			By what date the systemic changes will be completed; • Completion date: 11/16/23		
SS=E Bldg. 01	Cooking Facilities Cooking Facilities Cooking equipme accordance with	3				

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

Event ID:

Z4RE21

Facility ID: 000044

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X		(X3) DATE	X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B				COMPLETED	
		155106	B. W	B. WING 10/30/2			/2023	
		L	•	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER	t.	295 WESTFIELD RD					
	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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE	
		ing Operations, unless: ng equipment (i.e., small						
		ing equipment (i.e., smail is microwaves, hot plates,						
		I for food warming or limited						
	,	ance with 18.3.2.5.2,						
	19.3.2.5.2	arice with 10.0.2.3.2,						
		open to the corridor in						
		ents with 30 or fewer						
	•	ith the conditions under						
	18.3.2.5.3, 19.3.2.							
	· ·	in smoke compartments						
	•	atients 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	3 are not required to be						
	enclosed as hazaı	rdous areas, but shall not						
	be open to the cor							
		18.3.2.5.4, 19.3.2.5.1						
	through 19.3.2.5.5							
		on and interview, the facility	K 0	324	K 324		11/30/2023	
		kitchen range hood system in			We respectfully request desk			
		e requirements of LSC 9.2.3.			review in this matter. Thank yo	ou		
		commercial cooking			for your consideration.			
		installed in accordance with for Ventilation Control and			What corrective action(a):	ho		
		Commercial Cooking			What corrective action(s) will accomplished for those reside			
		96, 2011 edition, Section 6.2.4.1			found to have been affected b			
	_	hood system filters shall be			deficient practice;	y 1110		
	_	p tray beneath their lower			Table Practice,			
		Il be kept to the minimum size			No residents/staff were affect	ted		
	-	rease and shall be pitched to			by this alleged deficient practi			
		ed metal container having a			The kitchen hood drip pan			
		ling 1 gal (3.785 L). This			installation is scheduled for re	pair		
		ould affect up to 6 staff and			on or before 11/30/23 (See			
	visitors.				attachment B)			
					How other residents having th			
	Findings include:				potential to be affected by the			
					same deficient practice will be	)		
		ons and interview during a			identified and what corrective			
	tour of the facility v	with the Acting Maintenance			action(s) will be taken;			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLETED	
		155106	B. W	ING		10/30/2023	
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
DIVEDIA	ALIZAUL A OF				ESTFIELD RD		
RIVERW	ALK VILLAGE			NORLE	SVILLE, IN 46060		
(X4) ID	D SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CO			(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	LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)			DATE	
	Director and Field I	Maintenance Supervisor on					
	10/30/23 between 1	1:50 a.m. and 2:45 p.m., the			All residents/staff have the sales	ame	
	design of the kitche	n hood did not appear to			potential to be affected by this	i	
	provide for the coll	ection of grease from the			alleged deficient practice - The	е	
	kitchen hood. Greas	se was dripping down from the			kitchen hood drip pan installat	ion	
	hood and onto the f	loor behind and on the			is scheduled on or before 11/3	30/23	
	appliance. The Acti	ng Maintenance Director			(see attachment B). Maintena	nce	
	agreed and stated th	at the grease was not being			personnel have been educate	d on	
	captured in any drip	tray. Kitchen staff stated that			11/13/23 by the Senior Execu	tive	
	it had always been t	this way. The surveyor and the			Director on kitchen drip pan		
	-	e Director could not determine			operations (see attachment 1)	)	
		g to the system to meet the					
	*	ecting the grease in a drip tray,					
		ray was present as the grease					
		from the range hood system at					
		ey. The most recent record of a			What measures will be put into	0	
	-	ning from the facility's vendor			place or what systemic change		
	was dated 10/4/23 a	and close to the time of the		will be made to ensure that the			
	survey.				deficient practice does not rec	ur;	
	This finding was ac	knowledged at the time of			The kitchen drip pan hood		
	-	eting Maintenance Director,	installation is scheduled for				
		Supervisor and Executive			installation on or before 11/30	/23.	
		at the exit conference with the			(see attachment B) - Maintena		
		e Director, Field Maintenance			personnel were educated on		
		cutive Director all present.			11/13/23 by the Senior Execu	tive	
	•	•			Director on operations of kitch		
	3.1-19(b)				hood drip pan (see attachmer		
					- Maintenance to conduct aud	•	
					ensure compliance (see		
					attachment A)		
					ĺ		
					How the corrective action(s) w	ill be	
					monitored to ensure the defici	ent	
					practice will not recur, what qu	ıality	
					assurance program will be put	into	
					place;		
					Ongoing compliance with this	s	
					corrective action will be monite	ored	

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> B. WING		01	COMPLETED	
		155106	B. W	ING		10/30/	2023
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
RIVERW	ALK VILLAGE				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) COMPLETION
TAG	·	LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
K 0353 SS=F Bldg. 01	Sprinkler System - Automatic sprinkler are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and test secure location and a) Date sprinkler b) Who provided c) Water system  Provide in REMAR	supply source  RKS information on non-required or partial or system.			via facility QAPI program, with meetings being held monthly, is overseen by the Executive Director.  • CQI tool identified as kitchen hood drip pan functional (see attachment A) will be complete weekly x 4 weeks, monthly tim 6 months, and quarterly therea until compliance is achieved.  • If Threshold of 100% is not n an action plan will be develope ensure compliance.  By what date the systemic changes will be completed;  • Completion date: 11/30/23	and ed les after net,	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>		COMPLETED	
		155106	B. W	ING	10/30		2023
				CTREET	ADDRESS CITY STATE ZIR COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
DIVEDIA	ALIZAUL A OF				ESTFIELD RD		
RIVERW	ALK VILLAGE			NORLE	ESVILLE, 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	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Based on record rev	view and interview, the facility	K 0	353	K 353		11/16/2023
	failed to maintain 1	of 1 automatic sprinkler					
	systems in accordar	nce with NFPA 25. LSC 9.7.5			We respectfully request desk		
	requires all sprinkle	er systems shall be inspected,			review in this matter. Thank ye	ou	
	tested, and maintair	ned in accordance with NFPA			for your consideration.		
	25, Standard for the	Inspection, Testing, and			What corrective action(s) will I	be	
	Maintenance of Wa	ter-Based Fire Protection			accomplished for those reside	ents	
	Systems. NFPA 25	, 2011 Edition, Section 4.1.4.1			found to have been affected b	y the	
	states the property of	owner or designated			deficient practice;		
	representative shall	correct or repair deficiencies					
	or impairments that	are found during the			No residents/staff were affect	ted	
	inspection, test and	maintenance required by this			by this alleged deficient practi	ce -	
	standard. Corrections and repairs shall be				all deficiencies with our sprink	der	
	performed by qualit	fied maintenance personnel or			system in question have been	1	
	a qualified contract	or. NFPA 25, 4.3.1 requires			corrected		
	records shall be ma	de for all inspections, tests,			How other residents having th	ie	
	and maintenance of	the system components and	potential to be affected by the				
	shall be made avail	able to the authority having			same deficient practice will be	<b>;</b>	
	jurisdiction upon re	quest. This deficient practice			identified and what corrective		
	could affect all resid	dents, staff, and visitors in the			action(s) will be taken;		
	facility.						
					All residents/staff have the s	ame	
	Findings include:				potential to be affected by this	;	
					alleged deficient practice - all		
	Based on records re	eview and interview on 1030/23			deficiencies with our sprinkler		
		and 11:45 a.m. with the Acting			system in question have been		
		tor, Field Maintenance			corrected Maintenance person		
	-	cutive Director, the provided			have been educated on 11/13	/23	
	_	ording the facility's sprinkler			by the Senior Executive Direct	tor	
		eficiencies summary section of			on facility sprinkler system (se	е	
	•	3/8/2022 and 05/2/2023 several			attachment 1)		
		ncies were listed and didn't					
		corrected. Following					
		the main office and the					
		ntation was provided to show					
	the listed deficienci	es had been corrected.			What measures will be put into		
					place or what systemic chang		
		knowledged at the time of			will be made to ensure that the	1	
		eting Maintenance Director,			deficient practice does not rec	:ur;	
	Field Maintenance Supervisor and Executive						

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155106	(X2) MULTIPLE C A. BUILDING B. WING	onstruction  01	COMPLETED 10/30/2023		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD  295 WESTFIELD RD  NOBLESVILLE, IN 46060				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Out the exit conference with the	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	5.112		
	Acting Maintenanc Supervisor and Exe 3.1-19(b)	at the exit conference with the e Director, Field Maintenance cutive Director all present.		<ul> <li>All deficiencies with our spr system in question have bee corrected Maintenance personnel were educated on 11/13/23 by the Senior Exect Director on facility sprinkler system (see attachment 1) - Maintenance to conduct audiensure compliance (see attachment A)</li> <li>How the corrective action(s) monitored to ensure the deficient practice will not recur, what consume assurance program will be puplace;</li> <li>Ongoing compliance with the corrective action will be monivia facility QAPI program, with meetings being held monthly is overseen by the Executive Director.</li> <li>CQI tool identified as sprink system operational (see attachment A) will be completed weekly x 4 weeks, monthly tife months, and quarterly there until compliance is achieved.</li> <li>If Threshold of 100% is not an action plan will be developensure compliance.</li> <li>By what date the systemic changes will be completed;</li> <li>Completion date: 11/16/23</li> </ul>	utive  utive  it to  will be client quality ut into his tored ch , and  sler  ted mes eafter met,		
K 0355 SS=E	NFPA 101 Portable Fire Exti	nauishers					

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155106	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY  COMPLETED  10/30/2023		
	ROVIDER OR SUPPLIER ALK VILLAGE		STREET ADDRESS, CITY, STATE, ZIP COD 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
Bldg. 01	Portable Fire Extire Portable fire exting installed, inspecte accordance with Nertable Fire Extires 18.3.5.12, 19.3.5. Based on observation failed to ensure 1 of the Data room were NFPA 10, Standard 2010 Edition. Section extinguishers other shall be installed us means. (1) Securely extinguishers other shall be installed us means. (2) In extinguisher manufa approved for such precess. This deficient resident care area be Data Room.  Findings include:  Based on observation tour of the facility we Director and Field Medical 10/30/23 between 1 portable fire extinguishing on a A/C ledge on interview at the testing unsupported.  This finding was according to the finding was accordi	nguishers guishers are selected, d, and maintained in IFPA 10, Standard for nguishers. 12, NFPA 10 on and interview, the facility To portable fire extinguishers in installed in accordance with for Portable Fire Extinguishers, on 6.1.3.4 states portable fire than wheeled extinguishers ing any of the following on a hanger intended for the at the bracket supplied by the acture. (3) In a listed bracket surpose. (3) In a cabinet or wall at could affect 3 staff in the ons and interview during a with the Acting Maintenance Maintenance Supervisor on 1:50 a.m. and 2:45 p.m., an ABC sisher in the Data Room was ge and was unsecured. Based time of observation, the Acting or agreed the extinguisher was	K 0355	K 355  We respectfully request desk review in this matter. Thank ye for your consideration. What corrective action(s) will accomplished for those reside found to have been affected be deficient practice;  No residents/staff were affected by this alleged deficient practifire 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 sepotential to be affected by this alleged deficient practice - first extinguisher in question secur in appropriate manner - Maintenance personnel have educated on 11/13/23 by the Senior Executive Director on the extinguisher installation (see attachment 1)	11/16/2023  ou be ents by the sted ce -  ame s ents ame		
				•			

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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 <u>01</u>	(X3) DATE SURVEY COMPLETED 10/30/2023	
	PROVIDER OR SUPPLIE	ER	295 WI	ADDRESS, CITY, STATE, ZIP COD ESTFIELD RD ESVILLE, IN 46060	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(b)			What measures will be put in place or what systemic chang will be made to ensure that the deficient practice does not reconstruct the deficient practice on the secure of the security of the senior executive Director on extinguisher installation (see attachment 1) - Maintenance conduct audit to ensure compliance (see attachment of the security of the security of the security executive action will be puplace;  Ongoing compliance with the corrective action will be monitival facility QAPI program, with meetings being held monthly, is overseen by the Executive Director.  CQI tool identified as fire extinguisher installation (see attachment A) will be completed weekly x 4 weeks, monthly tire of months, and quarterly there until compliance is achieved.  If Threshold of 100% is not an action plan will be developed ensure compliance.	ges ne cur; n er - fire to A) will be cient uality ut into is tored h and ted mes cafter met,
				By what date the systemic	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155106	(X2) MULTIPLE C A. BUILDING B. WING	O1	COM	TE SURVEY PLETED 80/2023	
	PROVIDER OR SUPPLIEF		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 LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
				changes will be comp Completion date: 11/			
K 0363 SS=E Bldg. 01	than required enciexits, or hazardou of smoke and are solid-bonded core capable of resistir minutes. Doors in compartments are passage of smoke to rooms containing combustible mate hardware. Roller I CMS regulation. The apply to auxiliary a flammable or commodification complying to a complying the doors complying the door closed where the door closed where the permitted. Nonrate unlimited height a meeting 19.3.6.3.6 frames shall be la other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restri	rials have positive latching atches are prohibited by hese requirements do not spaces that do not contain bustible material. In bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping hen a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are red protective plates of re permitted. Dutch doors are permitted. Door beled and made of steel or compliance with 8.3,					

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>01</u>		COMPLETED		
		155106	B. W	B. WING			10/30/2023	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 295 WESTFIELD RD NOBLESVILLE, IN 46060					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID				(X5)	
PREFIX		CY 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 OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	NIE	DATE	
	assemblies.							
	19.3.6.3, 42 CFR 483, and 485 Show in REMARK fire protection rational devices, etc. Based on observational devices, etc. Based on observational devices, etc. Based on observational devices and would restrict the end of the facility of the	e door set leading into the loor was also missing a would allow the double doors	K 0	363	K 363  We respectfully request desk review in this matter. Thank you for your consideration.  What corrective action(s) will accomplished for those reside found to have been affected by deficient practice;  • No residents/staff were affected by this alleged deficient practice double door sets in question wall 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 sepotential to be affected by this alleged deficient practice - does door sets in question were all corrected and all latch positive Maintenance personnel have educated on 11/13/23 by the Senior Executive Director on corridor doors latching positive (see attachment 1)	ents y the  cted cce - vere  e  ame s uble ely - been	11/16/2023	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155106	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION  G <u>01</u>	COMP	(X3) DATE SURVEY COMPLETED 10/30/2023	
	PROVIDER OR SUPPLIEF	₹	STREET ADDRESS, CITY, STATE, ZIP COD 295 WESTFIELD RD NOBLESVILLE, IN 46060				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFII TAG	CROSS-REFERENCED TO THE AF	OULD BE	(X5) COMPLETION DATE		
				What measures will be place or what systemic will be made to ensure deficient practice does in the deficient practice will be made to ensure the practice will not recur, we assurance program will	changes that the not recur; estion have latch e personnel 3/23 by the tor on positively aintenance ure ment A) on(s) will be e deficient what quality		
				place; • Ongoing compliance vectorective action will be via facility QAPI programmeetings being held more is overseen by the Executive Director. • CQI tool identified as a doors latching positively attachment A) will be considered.	with this monitored m, with onthly, and cutive corridor y (see		
				weekly x 4 weeks, mon 6 months, and quarterly until compliance is achi • If Threshold of 100% i	thly times y thereafter eved.		

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an action plan will be developed to

ensure compliance.

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155106		A. BUILDING 01  B. WING		COMPLETED 10/30/2023			
	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 LSC IDENTIFYING INFORMATION	N TAG DEFICIENCY)		(X5) COMPLETION DATE		
				By what date the systemic changes will be completed; • Completion date: 11/16/23			
K 0754 SS=E Bldg. 01	shall not exceed 3 average density of room or space sha gallons/square fee capacity of 32 gall within any 64 squalinen or trash collecapacities greater located in a room area when not atted. Containers used spermitted to be exrequirements when than or equal to 96 and containers for	rash Containers ch collection receptacles 2 gallons in capacity. The container capacity in a all not exceed 0.5 t. A total container cons shall not be exceeded are feet area. Mobile soiled action receptacles with than 32 gallons shall be cortected as a hazardous ended. colely for recycling are cluded from the above re each container is less 5 gallons unless attended, combustibles are labeled ing FM Approval Standard					
	failed to ensure 2 of the corridor did not within a 64 square f practice could affect	on and interview, the facility 2 soiled linen receptacles in exceed 32 gallons in capacity oot area. This deficient a staff and up to 15 residents	K 0754	We respectfully request desk review in this matter. Thank yo for your consideration.			
	in the smoke compa			What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice;	nts		
	tour of the facility w Director and Field N	ons and interview during a with the Acting Maintenance Maintenance Supervisor on 1:50 a.m. and 2:45 p.m., there		No residents/staff were affect by this alleged deficient practic Soiled linen carts were remove	ce -		

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	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155106		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY  COMPLETED  10/30/2023	
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD 295 WESTFIELD RD NOBLESVILLE, IN 46060			
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY O were 2 large 33-ga corridor near resid interview at the tin Maintenance Direc the closet across th were being stored.  This finding was a discovery by the A Field Maintenance Director and again Acting Maintenance	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION  Illon soiled linen carts in the ent room 110. Based on ne of observation, the Acting eter stated that they belong in ne hall from where the carts  ecknowledged at the time of acting Maintenance Director, Supervisor and Executive at the exit conference with the ene Director, Field Maintenance ecutive Director all present.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDEFICIENCY)  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 sepotential to be affected by this alleged deficient practice - so linen carts were removed from corridor- Maintenance person have been educated on 11/13 by the Senior Executive Director on soiled linen cart storage (seattachment 1)  What measures will be put integrated by the senior executive deficient practice on soiled linen cart storage (seattachment 1)  **What measures will be put integrated on 11/13/23 by the Senior Executive Director on soiled linen cart storage (see attachment 1) - Maintenance (see attachment 1) - Maintenance to conduct auditions and the service of t	pate  Date  Date	
				ensure compliance (see attachment A)  How the corrective action(s) was monitored to ensure the deficiency practice will not recur, what quassurance program will be put	will be ient uality	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155106		A. BUILDING <u>01</u> COMPLE		(X3) DATE SURVEY  COMPLETED  10/30/2023	
	PROVIDER OR SUPPLIEF	8	295 W	ADDRESS, CITY, STATE, ZIP COD ESTFIELD RD ESVILLE, IN 46060	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				place; • Ongoing compliance with this corrective action will be monitor via facility QAPI program, with meetings being held monthly, is overseen by the Executive Director. • CQI tool identified as soiled a carts stored appropriately (see attachment A) will be completed weekly x 4 weeks, monthly time 6 months, and quarterly there until compliance is achieved. • If Threshold of 100% is not in an action plan will be developed ensure compliance.  By what date the systemic changes will be completed; • Completion date: 11/16/23	and inen e ed nes after
K 0781 SS=E Bldg. 01	prohibited in all he except, unless use employee areas we do not exceed 212 degrees Celsius). 18.7.8, 19.7.8  Based on observation failure to ensure 1 of were not used in the practice could affect.  Findings include:	eaters eating devices shall be eatth care occupancies, ed in nonsleeping staff and where the heating elements 2 degrees Fahrenheit (100 on and interview, the facility of 1 portable space heaters e facility. This deficient	K 0781	K 781  What corrective action(s) will be accomplished for those residents/staff found to have be affected by the deficient practi	peen

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155106		(X2) MULTIPLE CO A. BUILDING B. WING					
NAME OF PROVIDER OR SUPPLIER RIVERWALK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 295 WESTFIELD RD NOBLESVILLE, IN 46060				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION with the Acting Maintenance	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	Director and Field I 10/30/23 between 1 portable space heater Room. Based on into observations, the Fi agreed a space heater recently been unplue extremely hot to the Maintenance Direct Supervisor each stanot to use portable the building and the written policy was a survey, however the Director, Field Maintenance of the policy was a survey by the Acting Maintenance of the policy by the Acting Maintenance of the policy by the Acting Maintenance of the policy and policy by the Acting Maintenance of the policy and	Maintenance Supervisor on 1:50 a.m. and 2:45 p.m., a er was in use in the Data terview at the time of the eld Maintenance Supervisor er was being used and had gged as the unit was still		No residents/staff were affect by this alleged deficient practic. The space heater in question removed from the data room a 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 sepotential to be affected by this alleged deficient practice - spate heater in question was remove from the data room and from the property - Maintenance personnel have been educate 11/13/23 by the Senior Execut Director on space heater usage (see attachment 1)  What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not reconstructed from the data room a removed from the data room a 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	ce - was and e ame ace ed he d on tive ge		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155106		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 10/30/2023	
	ROVIDER OR SUPPLIE	ER	295 \	ET ADDRESS, CITY, STATE, ZIP COD WESTFIELD RD LESVILLE, IN 46060	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IS CROSS-REFERENCED TO THE APPROP DEFICIENCY)  compliance (see attachmen	RIATE COMPLETION DATE
				How the corrective action(s) monitored to ensure the def practice will not recur, what assurance program will be place;  • Ongoing compliance with corrective action will be more via facility QAPI program, we meetings being held monthly is overseen by the Executive Director.  • CQI tool identified as no synthemater usage in facility (see attachment A) will be compleweekly x 4 weeks, monthly 6 months, and quarterly the until compliance is achieved • If Threshold of 100% is no an action plan will be developed ensure compliance.  By what date the systemic changes will be completed;  • Completion date: 11/16/25	icient quality put into  this nitored ith y, and e  pace e eted times reafter d. t met, pped to
K 0920 SS=E Bldg. 01	Extens Electrical Equipn Extension Cords Power strips in a used for compon patient-care-rela	patient care vicinity are only			

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assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155106	A. BUILDING <u>01</u> COMPLE		(X3) DATE SURVEY COMPLETED 10/30/2023	
NAME OF PROVIDER OR SUPPLIER RIVERWALK VILLAGE			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 LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	non-PCREE (e.g., except in long-term do not use PCREI meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care mother UL standard used with general cords are not used wiring of a structu temporarily are recompletion of the installed and mee 10.2.3.6 (NFPA 99 (NFPA 70), 590.3). Based on observation failed to ensure 1 or as a substitute for find 400.8 state unless is flexible cords and coas a substitute for find practice could affect maintenance office.  Findings include:  Based on observation tour of the facility with the properties of the facility with the facility of the facility with the facility of the facility with	ons and interview during a with the Acting Maintenance Maintenance Supervisor on 1:50 a.m. and 2:45 p.m., in the office area, a ceiling light was green extension cord. Based time of observation, the Acting or acknowledged an extension	K 0920	K 920  We respectfully request desk review in this matter. Thank y for your consideration. What corrective action(s) will accomplished for those reside found to have been affected by 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 have the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken;  • All residents/staff have the sepotential to be affected by this	be ents by the  cted ice -  ing the e	

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	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155106	(X2) MULTIPLE C A. BUILDING B. WING	onstruction  01	(X3) DATE SURVEY COMPLETED 10/30/2023			
NAME OF PROVIDER OR SUPPLIER RIVERWALK VILLAGE			295 W	STREET ADDRESS, CITY, STATE, ZIP COD 295 WESTFIELD RD NOBLESVILLE, IN 46060				
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
	Director and again Acting Maintenanc	Supervisor and Executive at the exit conference with the e Director, Field Maintenance excutive Director all present.		alleged deficient practice - extension cord in question hat been removed and replaced of appropriate power cord Maintenance personnel have educated on 11/13/23 by the Senior Executive Director on appropriate power cord usage attachment 1)  .  What measures will be put interplace or what systemic change will be made to ensure that the deficient practice does not reconstructed.	with - been e (see			
				replaced with appropriate porcord - Maintenance personne educated on 11/13/23 by the Senior Executive Director on proper power cord usage (seattachment 1) - Maintenance conduct audit to ensure compliance (see attachment a	el was e to			
				How the corrective action(s) we monitored to ensure the defice practice will not recur, what quassurance program will be puplace;  • Ongoing compliance with the corrective action will be monivia facility QAPI program, with meetings being held monthly is overseen by the Executive Director.	ient uality ut into is tored h			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155106		X2) MULTIPLE CONSTRUCTION A. BUILDING D1 B. WING		COMPI	(X3) DATE SURVEY COMPLETED 10/30/2023			
NAME OF PROVIDER OR SUPPLIER RIVERWALK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP COD 295 WESTFIELD RD NOBLESVILLE, IN 46060				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAC	CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE		
	• 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		achment ly x 4 onths, ntil not met, eloped to					

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