

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155695	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2014
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NAME OF PROVIDER OR SUPPLIER RIVERSIDE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN 46516
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 05/20/14</p> <p>Facility Number: 003075 Provider Number: 155695 AIM Number: 200364160</p> <p>Surveyor: Dennis Austill, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Riverside Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with a partial basement was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in spaces open to the corridors. The facility has 48 resident</p>	K010000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after June 19, 2014.	

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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K010018 SS=E	<p>rooms with battery operated smoke detectors. The facility has a capacity of 97 and had a census of 836 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except a detached shed used for storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/29/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p>				

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K010047 SS=D	<p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure the door to 1 of 1 therapy rooms was provided with positive latching hardware. This deficient practice had the potential to affect at least 5 residents and staff using the therapy room.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director at 1:30 p.m. on 05/20/14, the door to the therapy room was provided with a dead bolt that had to be manually latched. Based on interview at the time of observation, the Executive Director acknowledged the therapy room door was not provided with positive latching hardware.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 Based on observation and interview, the facility failed to ensure 2 of 7 basement exit signs were continuously illuminated.</p>	K010018	K018-The door to the therapy gym has been repaired to ensure that the door latches into its frame. All residents have the ability to be affected. The Maintenance Staff conducted a full facility audit of all of the corridor doors to ensure they properly latch. The Maintenance Supervisor or designee will monitor the locks/latching devices throughout the facility. Doors will be reviewed as part of the CQI program. The Maintenance Director or designee will audit locks/ latching devices monthly for at least 6 months. The Maintenance Director or designee will record their findings on the "locks/latching devices" audit tool. If the audit results in anything lower than 100% then the Director or designee will correct the deficiency immediately.	06/19/2014
		K010047	K047-Proper signage to alert staff and visitors to direction of nearest "Exit" has been repaired to the exit sign near the basement rehab	06/19/2014

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K010050 SS=F	<p>This deficient practice had the potential to affect staff in the basement.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director on 05/20/14 from 1:00 p.m. to 3:00 p.m., the exit sign near the basement rehab therapy storage room and the exit sign at the emergency exit to Hudson Street were not illuminated. Based on interview at the time of observation, the Executive Director acknowledged the exit signs were not illuminated.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>1. Based on interview and record review, the facility failed to conduct quarterly fire drills on each shift for 1 of 4 quarters.</p> <p>This deficient practice affects all</p>	K010050	<p>therapy storage and the exit sign at the emergency exit to Hudson Street. This deficient practice had the potential to affect all residents. All exits signs were observed by Maintenance Director to ensure proper illumination. The Maintenance Director or designee will assess all Exit signs weekly for 4 weeks and monthly ongoing to ensure proper operation. Audits will be completed and logged as part of our Preventative Maintenance Program. If the audit results in anything lower than 100% then the Director or designee will correct the deficiency immediately. The audits will be reviewed monthly by the Executive Director as part of our Preventative Maintenance Program and concerns brought forward as part of the CQI program.</p> <p>K050</p> <p>1. All fire drills will be conducted each quarter on each shift at unexpected times and will be</p>	06/19/2014

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	<p>occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of "Monthly Fire Drill Reports" with the Executive Director from 11:45 a.m. to 1:00 p.m. on 05/20/14, a fire drill was not documented for the third shift of the fourth quarter of 2013. Based on interview at the time of record review, the Executive Director acknowledged a fire drill for the third shift of the fourth quarter of 2013 was not documented and there was no other documentation available for review to verify a drill was conducted during this time period.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>2. Based on record review and interview, the facility failed to conduct fire drills under varied conditions in 5 of 12 fire drills. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of "Monthly Fire Drill Reports" with the Executive Director from 11:45 a.m. to 1:00 p.m. on</p>		<p>reviewed monthly by the Executive Director. All residents have the potential to be affected. Fire drills will be recorded on the "Monthly Fire Drill Report." If the audit results in anything lower than 100% then the Director or designee will correct the deficiency immediately. The audits will be reviewed as part of the CQI program.</p> <p>2. Fire Drills will have a more descriptive simulated situation documented on the monthly fire drill report. All residents have the potential to be affected. Fire drills will be reviewed monthly by Executive Director to ensure simulated situation is properly documented with more specificity. The audit will be reviewed as part of the CQI program.</p>	

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K010066 SS=D	<p>05/20/14, the "Describe Simulated Situation" section of the fire drills conducted on 05/21/13, 07/31/13, 12/18/13 and 04/02/13 indicated "cloth" and on 06/03/13 indicated "simulated." Based on interview at the time of record review, the Executive Director acknowledged the aforementioned fire drill report simulations were not descriptive.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover</p>						

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K010069 SS=D	<p>devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure trash and cigarette butts in 1 of 1 areas where smoking was permitted for staff were not commingled. This deficient practice could affect staff using the smoking area.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director during a tour of the facility on 05/20/14 from 1:00 p.m. to 3:00 p.m., a 30 gallon container at the designated smoking area for staff outside the facility contained cigarette butts commingled with paper trash. Based on interview at the time of observation, the Executive Director acknowledged the commingled trash and cigarette butts.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 1998 Edition,</p>	K010066	<p>K066-Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. All residents have the potential to be affected. All smoke areas were observed by Maintenance Director or designee to ensure no trash and cigarette butts were comingled. Trash is not to comeingle with potentially combustible material. Employees have been in-serviced regarding proper disposal of cigarette butts. Maintenance Director or designee will inspect area daily for 4 weeks and weekly for 6 months to ensure proper disposal of cigarette butts. Inspections will be tracked on in our Preventative Maintenance Manual. The audits will be reviewed by the Executive Director monthly. If the audit results in anything lower than 100% then the Director or designee will correct the deficiency immediately. The audits will be reviewed as part of the CQI program.</p>	06/19/2014
		K010069	<p>K069- The kitchen exhaust system has been inspected and is operating properly and is properly tagged. All residents have the potential to be affected. There</p>	06/19/2014

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	<p>Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires the entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1, Exhaust System Inspection Schedule, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 8-3.1.1 says, upon inspection, if found to be contaminated with deposits from grease laden vapors, the entire exhaust system shall be cleaned in accordance with Section 8-3. NFPA 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. This deficient practice could affect staff in the kitchen.</p> <p>Findings include:</p> <p>Based on record review with the Executive Director from 11:45 a.m. to 1:00 p.m. on 05/20/14, documentation of the most recent semiannual kitchen exhaust system inspection was dated 05/06/14. The previous available</p>		<p>are no other kitchen exhaust systems in the facility. The kitchen exhaust system must be inspected and serviced every six months. Inspection of the kitchen exhaust system is a contracted service that will be completed every six months. The inspection will be monitored by the Maintenance Director or designee with appropriate signage displayed on the hood exhaust system to verify inspection. The inspection will be reflected every 6 months in our Preventative Maintenance Manual and reviewed by the Executive Director</p>				

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	documented semiannual kitchen exhaust system inspection was dated 10/21/13, a period greater than six months. Based on interview at the time of record review, the Executive Director acknowledged the interval between kitchen exhaust inspections exceeded six months. 3.1-19(b)				