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 08/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE VILLAGE	1400 W FRANKLIN ST ELKHART, IN 46516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 07/21/16 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 08/31/16 Facility Number: 003075 Provider Number: 155695 AIM Number: 200364160 At this PSR 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. This one story facility with a partial basement 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, spaces open to the corridors	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	and battery operated smoke alarms were installed in the resident rooms. The facility has a capacity of 97 and had a census of 92 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except a detached shed used for storage. Access was not readily available to four rooms in the basement which per the Maintenance Director, were spaces that residents do not have normal access to. Quality Review completed on 09/06/16 - DA			
K 0025 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an	K 0025	Basement Soiled Utility room had a one inch ceiling gap around a piece of drywall that was cut out and replaced.	09/29/2016

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	outside wall. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Director on 08/31/16 at 3:44 p.m., Basement Soiled Utility room had a one inch ceiling gap around a piece of drywall that was cut out and replaced. Based on interview at the time of observation, the Maintenance Director acknowledged and provided the measurement for the unsealed penetration. 3.1-19(b) This deficiency was cited on 07/21/16. The facility failed to implement a systemic plan of correction to prevent recurrence.		**What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** All ceiling penetrations on the smoke barrier were properly fire stopped with repair and the use of fire caulking. **How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?** No other smoke barrier wall were identified as having penetration/holes/gaps remaining in wall that are not properly fire stopped. **What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur?** Any possible future work which may involve penetration of a smoke barrier wall, will be inspected following work to ensure that there are no space/holes/gaps remaining in wall that are not properly fire stopped.	

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			How will the corrective action be monitored to ensure that alleged deficient practice will not recur(what quality assurance program will be put into place? Any future renovations will be reviewed through the QA&A to ensure that all state and federal regulations have been met.	
K 0130 SS=D Bldg. 01	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 The facility failed to provide access to 4 of 4 locked rooms within the facility. According to the State Operations Manual 2833C.2a (E) requires any locked areas which require a key for entry to be accessible to surveyors. This deficient practice could affect staff only. Findings include: Based on observation and interview on 08/31/16 between 2:49 p.m. and 4:42 p.m., the Maintenance Director acknowledged that four rooms in the basement were locked and no staff member was able to provide a key to allow the rooms to be surveyed. 3.1-19(b)	K 0130	OTHER LSC DEFICIENCY NOT ON 2786 The facility failed to provide access to 4 of 4 Locked rooms within the facility. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** All rooms in facility have keys available for entry if requested to enter a room. Maintenance/ designee will keep said keys in a designated location. **How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be**	09/29/2016

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			taken? No residents have potential to be affected by this issue. The four rooms affected were locked for HIPPA protection. The rooms stored medical records and past financial information for residents and facility. All future locks changed in facility will have a labeled key with the location labeled and placed with the maintenance director/designee. **What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur?** All future locks changed in facility will have a labeled key with the location labeled and placed with the maintenance director /designee. This will ensure that every room in facility is available for inspection. **How will the corrective action be monitored to ensure that alleged deficient practice will not recur(what quality assurance program will be put into place?** Any future door lock changes/replacements will be reviewed through the QA&A to ensure that all state and federal regulations have been met.	

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			By what date the systemic changes will be completed. September 29, 2016	