

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 06/09/2015
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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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K 0000 Bldg. 01	<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: 06/09/15</p> <p>Facility Number: 003075 Provider Number: 155695 AIM Number: 200364160</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 (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and hard wired smoke detectors in all resident rooms on the 400 hall. Battery</p>	K 0000	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 July 9, 2015.	

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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K 0018 SS=E Bldg. 01	<p>operated smoke alarms were installed in the resident rooms. The facility has a capacity of 97 and had a census of 86 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>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> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 1 Therapy room corridor doors closed and latched into the door frame. This deficient practice could affect at least 3 residents in the Therapy room.</p>	K 0018	<p>It is the practice of this facility to ensure that a safe environment is afforded to our residents and as a portion of this that doors appropriately latch.</p> <p>K - 18</p>	07/09/2015	

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	<p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 06/09/15 at 2:21 p.m., the corridor door entering the Therapy room failed to latch into the door frame. Based on an interview at the time of observation, the Maintenance Supervisor stated the Therapy door failed to latch because the latching mechanism was stuck.</p> <p>3.1-19(b)</p>		<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>There were no specifically identified residents affected by this finding. The maintenance director repaired the latching mechanism on the therapy room door to ensure that it appropriately latches upon closure.</p> <p>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:</p> <p>All residents have the potential to be affected by the finding. An audit of all doors in the facility occurred to ensure latching mechanisms were functioning. Appropriate repairs to any other doors with latching issues were made.</p> <p>What measures will be put into place or what systemic changes will be made to practice does not recur:</p> <p>The maintenance director will receive education on the preventative maintenance program from the area maintenance director as well as identification of improperly</p>		

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K 0025 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>1. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 5 smoke barrier walls was protected to maintain the smoke resistance of each smoke</p>	K 0025	<p>latching doors as a portion of hisfacility routine rounding program.</p> <p>Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place:</p> <p>To ensure ongoingcompliance with this corrective action, the ED/Maintenance Director/designee will be responsible for completion of the CQI Audit Tool titled, "Door Safety"daily for 3 weeks and weekly for 6 months. If threshold of 90% is not met</p> <p>K- 25</p> <p>Itis the practice of this facility to ensure that smoke barriers are maintainedin accordance with standard.</p> <p>Whatcorrective action(s) will be</p>	07/09/2015			

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	<p>barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 2 of 5 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation and interview on 06/09/15 at 3:35 p.m., the Maintenance Supervisor acknowledged the attic smoke barrier wall near the 200 hall nurse's station had unsealed penetration measuring one inch around internet cables.</p> <p>3.1-19(b)</p> <p>2. 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 outside wall. This deficient practice was</p>		<p>accomplished for those residents found to have been affected by the deficient practice:</p> <p>There were no specifically identified residents affected by this finding. The one inch penetration around the internet cables in the attic smoke barrier wall near the 200 hall nurses station has been sealed with smoke resistant caulk. The four unsealed ceiling penetrations in the IT storage room around the internet and phone lines have been sealed with smoke resistant caulk.</p> <p>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:</p> <p>All residents have the potential to be affected by the finding. Each of the smoke barrier areas was evaluated to ensure any other penetrations were properly sealed.</p> <p>What measures will be put into place or what systemic changes will be made to practice does not recur:</p> <p>The maintenance director will be serviced prior to 7.9.15 on the preventative maintenance program by the area</p>				

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K 0027 SS=E Bldg. 01	<p>not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on an observation and interview on 06/09/15 at 3:25 p.m., the Maintenance Supervisor acknowledged there were four unsealed ceiling penetrations in the IT storage room measuring in the size from one fourth inch to one eight inch around internet and phone lines.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with</p>		<p>maintenance director and to ensure that any other instances where future work is being completed which may involve the penetration of a smoke barrier wall, will be inspected following work to ensure that there are no spaces/holes or gaps remaining in a wall that are not properly sealed.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>To ensure ongoing compliance with this corrective action, the Maintenance Director/designee will be responsible for completion of the Audit Tool titled, "Door Safety" daily for 3 weeks and weekly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up.</p>		

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	<p>19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 5 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.6 requires doors in smoke barriers shall comply with LSC Section 8.3.4. LSC 8.3.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. The deficient practice could affect 2 of 5 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 06/09/15 at 2:56 p.m., the smoke barrier doors near resident room 113 were equipped with an astragal. Based on an interview with the Maintenance Supervisor at the time of observation, there was a coordinating device for this set of smoke barrier doors but he is not sure what happened to it.</p> <p>3.1-19(b)</p>	K 0027	<p>K-27</p> <p>It is the practice of this facility to maintain the integrity of doors to ensure that smoke barriers are present.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>There were no specifically identified residents affected by this finding. The smoke barrier doors near room 113 were repaired to include the replacement of the coordinating device.</p> <p>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:</p> <p>All residents have the potential to be affected by the finding. Each of the smoke barrier doors in the facility were audited for function and any necessary repairs were made.</p> <p>What measures will be put into place or what systemic changes will be made to practice does not recur:</p>	07/09/2015

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K 0029 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are		The maintenance director will beinserviced by the area maintenance director prior to 7.9.15 on the preventativemaintenance program and the required inspection of smoke barrier doors forintegrity and function during monthly rounds. Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place: To ensure ongoing compliance with thiscorrective action, the Maintenance Director/designee will be responsible for completion of the Audit Tooltitled, "Smoke Barrier Penetrations" daily for 3 weeks and weekly for 6 months. If threshold of 90% is not met, an action plan will be developed.Findings will be submitted to the CQI Committee for review and follow up.	

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	<p>self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 4 of 5 hazardous areas, such as water heater rooms, soiled linen rooms, laundry rooms and combustible storage areas over 50 square feet in size, were self closing and latch into the door frame. This deficient practice could affect residents 21 residents in the 200 hall and 18 residents in the 400 hall.</p> <p>Findings include:</p> <p>Based on an observation with the Executive Director and the Maintenance Supervisor on 06/09/15 from 2:15 p.m. to 4:12 p.m., the following was noted:</p> <p>a) The corridor door to the 200 hall and the 400 hall soiled linen storage rooms failed to latch into the door frame.</p> <p>b) The corridor door to the 500 hall water heater/housekeeping storage room stopped on an uneven area of the floor which prevented the door from self closing and latching into the door frame.</p> <p>c) The corridor door designated as "laundry out" in the basement laundry room did self close but failed to latch into the door frame.</p> <p>d) The basement corridor door to the medical records storage room, containing</p>	K 0029	<p>K-29</p> <p>It is the practice of this facility to maintain the integrity of doors and their proper function to ensure resident safety.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>There were no specifically identified residents affected by this finding. The corridor door and latch mechanism to the 200 hall and 400 hall soiled linen storage rooms was repaired. The door to the 500 hall water heater area was repaired to allow for free flow of the door to allow for self closing and latching into the frame. The "laundry out" door frame in the basement laundry room was repaired to allow the door to latch. The door and latch mechanism in the medical records room was repaired.</p> <p>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:</p> <p>All residents have the potential to</p>	07/09/2015

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K 0038 SS=D	50 cardboard boxes of medical records, failed to self close and latch into the door frame. Based on an interview with the Maintenance Supervisor at the time of observation, the self closing device had pulled out of the drywall. 3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD		beaffected by the finding. Each of the smokersisting doors in the facility were audited for function and any necessaryrepairs were made. Whatmeasures will be put into place or what systemic changes will be made topractice does not recur: The maintenance director will be inservedby the area maintenance director prior to 7.9.15 on the preventativemaintenance program and the required inspection of smoke resisting doors forintegrity and function during monthly rounds. Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place: To ensure ongoing compliance with thiscorrective action, the Maintenance Director/designee will be responsible for completion of the Audit Tooltitled, "Door Safety" daily for 3 weeks and weekly for 6 months. If threshold of 90% is not met, an action plan will be developed.Findings will be submitted to the CQI Committee for review and follow up.		

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Bldg. 01	<p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 doors from the kitchen was provided with door latches readily operated under all lighting conditions. LSC 7.2.1.5.4 requires where a latch or other similar device is provided, the method of operation of its releasing device must be obvious, even in the dark. The intention of this requirement is the method of release be one which is familiar to the average person. For example, a two step release, such as a knob and independent dead bolt, is not acceptable. In most occupancies, it is important a single action unlatch the door. This deficient practice was not in a resident care area but could affect kitchen staff.</p> <p>Findings include:</p> <p>Based on observation with Maintenance Supervisor on 06/09/15 at 3:50 p.m., the kitchen corridor door was equipped with an independent dead bolt in addition to the door knob. Based on an interview with the Maintenance Supervisor at the time of observation, he acknowledged the kitchen door had an independent dead bolt.</p>	K 0038	<p>K-38</p> <p>It is the practice of this facility to maintain the integrity of doors and their proper function to ensure resident safety.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>There were no specifically identified residents affected by this finding. The deadbolt mechanism was removed from the kitchen door to allow a single action to unlock the door.</p> <p>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:</p> <p>All residents have the potential to be affected by the finding. Each of the locking doors in the facility were audited to ensure a single action for unlock was present.</p> <p>What measures will be put into place or what systemic changes will be made to practice does not recur:</p> <p>The maintenance director will</p>	07/09/2015			

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K 0043 SS=D Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Patient room doors are arranged so that the patient can open the door from inside without using a key. (Special door locking arrangements are permitted in mental health facilities.) 19.2.2.2.2 Based on observation, the facility failed to ensure 1 of 48 resident rooms was arranged such that the residents can open the door from inside without using a key. This deficient practice could affect 2 of 86 residents.</p>	K 0043	<p>beinserviced by the area maintenance director prior to 7.9.15 on the preventativemaintenance program and to ensure that locking doors are free of deadboltsduring monthly rounds.</p> <p>Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place: To ensure ongoing compliance with thiscorrective action, the Maintenance Director/designee will be responsible for completion of the Audit Tooltitled, "Door Safety" daily for 3 weeks and weekly for 6 months. If threshold of 90% is not met, an action plan will be developed.Findings will be submitted to the CQI Committee for review and follow up.</p> <p>K-43</p> <p>Itis the practice of this facility to maintain the integrity of doors and theirproper function to ensure resident safety.</p> <p>Whatcorrective action(s) will be</p>	06/11/2015	

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	<p>Findings include:</p> <p>Based on observation with the Executive Director and the Maintenance Supervisor on 06/08/15 at 2:10 p.m., the corridor door to resident room 406 had a lockable door knob which could lock from the corridor side of the door requiring a key from inside the resident room in order to unlock the door. Based on an interview at the time of observation, the Maintenance Supervisor stated when he needed to replace the original door knob this was the only door knob available at the time.</p> <p>3.1-19(b)</p>		<p>accomplished for those residents found to have been affected by the deficient practice:</p> <p>There were no specifically identified residents affected by this finding. The door knob to room 406 was replaced with a handle without a locking mechanism.</p> <p>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:</p> <p>All residents have the potential to be affected by the finding. Each of the resident room doors in the facility was audited to ensure that no other handles with locking mechanism were present.</p> <p>What measures will be put into place or what systemic changes will be made to practice does not recur:</p> <p>The maintenance director will be serviced by the area maintenance director prior to 7.9.15 on the preventative maintenance program and to ensure that a locking knob is never used on a resident room door.</p> <p>How the corrective action(s) will be monitored to ensure the</p>		

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K 0046 SS=C Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation, record review and interview; the facility failed to ensure 32 of 32 emergency light fixtures of at least 1½ hour duration were tested annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires that an annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could</p>	K 0046	<p>deficient practicewill not recur, i.e., what quality assurance program will be put into place: To ensure ongoing compliance with thiscorrective action, the Maintenance Director/designee will be responsible for completion of the Audit Tooltitled, "Door Safety" daily for 3 weeks and weekly for 6 months. If threshold of 90% is not met, an action plan will be developed.Findings will be submitted to the CQI Committee for review and follow up.</p> <p>K-46</p> <p>Itis the practice of this facility to maintain a safe environment for staff andresidents to include the function of emergency lighting.</p> <p>Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice:</p> <p>There were no specifically identified residents affected by thisfinding. The battery operated emergencylights in the facility will be tested for a one and a half hour duration on orbefore July</p>	07/09/2015			

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	<p>affect all occupants.</p> <p>Findings include:</p> <p>Based on observations with the Executive Director and the Maintenance Supervisor on 06/08/15 during a tour of the facility from 1:40 p.m. and 4:15 p.m., battery operated emergency lights were observed throughout the facility. Based on record review and interview at 1:28 p.m., the Maintenance Supervisor confirmed the last annual test for the 32 emergency lights took place in March 2014.</p> <p>3.1-19(b)</p>		<p>9th, 2015.</p> <p>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:</p> <p>All residents have the potential to be affected by the finding. During the test of the emergency lights was audited for function and necessary repairs made as needed.</p> <p>What measures will be put into place or what systemic changes will be made to practice does not recur:</p> <p>The maintenance director will be serviced by the area maintenance director prior to 7.9.15 on the preventative maintenance program and to the requirement of testing emergency lighting in the facility annually for a minimum of one and a half hours.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>To ensure ongoing compliance with this corrective action, the Maintenance Director/designee will be responsible for bringing the annual inspection of emergency lighting to the Safety</p>		

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K 0050 SS=C Bldg. 01	<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>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 4 of 4 quarters. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review of the "Monthly Fire Drill Report" forms with the Administrator and the Maintenance Supervisor on 06/08/15 at 12:43 p.m., all fire drills for the previous year took place between the 26th and the 31st of each month. Additionally, the documentation for October 2014, March and May 2015</p>	K 0050	<p>Committee meeting monthly to review annual inspection compliance. Findings will be submitted to ED for immediate resolve and as needed as well as to the the CQI Committee for review and followup.</p> <p>K-50</p> <p>It is the practice of this facility to ensure adequate disaster preparedness to include the staggering of fire drills and documenting the type of fire simulated.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>There were no specifically identified residents affected by this finding. The fire drill for the month of June was held on June 24 which was outside of the trend</p>	07/09/2015

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	<p>did not include type of fire simulated. This was acknowledged by the Administrator at the time of record review.</p> <p>3.1-19(b) 3.1-51(c)</p>		<p>dates identified with the type of fire simulated documented.</p> <p>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:</p> <p>All residents have the potential to be affected by the finding. A schedule of staggered fire drills for the remainder of the year along with types of fires simulated was established to promote a staggered routine to the drills.</p> <p>What measures will be put into place or what systemic changes will be made to practice does not recur:</p> <p>The maintenance director will be serviced by the area maintenance director prior to 7.9.15 on the preventative maintenance program and to the requirement of staggering the dates of fire drills throughout the calendar months as well as ensuring that the type of fire is clearly documented with each drill.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>To ensure ongoing compliance</p>	

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K 0056 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure complete automatic sprinkler system was provided for 1 of 1 elevator shaft in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. " NFPA 13, 1999 Edition Standard for the</p>	K 0056	<p>with this corrective action, the Maintenance Director/designee will be responsible for bringing the monthly fire drill to the Safety Committee meeting monthly to review the staggering of drills as well as the type of fire simulated. Findings will be submitted to ED for immediate resolve and as needed as well as to the the CQI Committee for review and followup.</p> <p>K-56</p> <p>It is the practice of this facility to ensure adequate disaster preparedness to include a functional sprinkler system with adequate head coverage.</p> <p>What corrective action(s) will be accomplished for those residents found to have been</p>	07/09/2015

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	<p>Installation of Sprinkler Systems at 5-13.6.3 requires that upright or pendent spray sprinklers shall be installed at the top of elevator hoistways.</p> <p>Exception: Sprinklers are not required at the tops of noncombustible hoistways of passenger elevators with car enclosure materials that meet the requirements of ASME A17.1, Safety Code for Elevators and Escalators.</p> <p>This deficient practice could affect any resident near the elevator in the event of an emergency.</p> <p>Findings include:</p> <p>Based on an observation and interview on 06/09/15 at 2:23 p.m., the Maintenance Supervisor confirmed the elevator shaft lacked sprinkler coverage. He stated the elevator was hydraulically driven and the elevator car had a wood interior surface.</p> <p>3.1-19(b)</p>		<p>affected by the deficient practice:</p> <p>There were no specifically identified residents affected by this finding. The fire safety contractor has submitted a proposal for the placement of a sprinkler head in the elevator shaft and the completion of the work will be completed at their earliest scheduling opening to be no later than August 8, 2015.</p> <p>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:</p> <p>All residents have the potential to be affected by the finding. No other elevator shafts are present in the facility, but as a general precaution, the fire safety contractor inspected the fire sprinkler system for function and head placement with no other areas of concern identified.</p> <p>What measures will be put into place or what systemic changes will be made to practice does not recur:</p> <p>The maintenance director will be serviced by the area maintenance director prior to 7.9.15 on the preventative maintenance program and to identification of areas that have the potential</p>				

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K 0066 SS=B Bldg. 01	<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</p>		<p>to require sprinkler heads in the event of structural changes to the facility.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>To ensure ongoing compliance with this corrective action, the Maintenance Director/designee will be responsible for bringing the annual sprinkler inspections to the monthly safety committee for review and evaluation. Findings will be submitted to ED for immediate resolve and as needed as well as to the CQI Committee for review and follow up.</p>	

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	<p>smoking is permitted.</p> <p>(4) Metal containers with self-closing cover 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 1 of 1 staff smoking areas was provided with a self closing trash receptacle used to empty ashtrays only. This deficient practice could affect residents in the smoking area and facility staff.</p> <p>Findings include:</p> <p>Based on observation and interview, the Maintenance Director on 06/09/15 at 2:20 p.m., acknowledged the staff smoking area did not have a metal container with a self closing covered receptacle provided to empty ashtrays.</p> <p>3.1-19(b)</p>	K 0066	<p>K-66</p> <p>It is the practice of this facility to ensure appropriate measures are in place to promote a safe environment.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>There were no specifically identified residents affected by this finding. A self closing covered receptacle to empty ash trays was placed in the smoking area.</p> <p>How often residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>All residents have the potential to be affected by the finding. The smoking area will be inspected daily by the maintenance department or designee to ensure that the ashes have been appropriately discarded and the self closing covered receptacle is available.</p>	07/09/2015	

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K 0068 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 water heater rooms in the 500 hall was	K 0068	<p>What measures will be put into place or what systemic changes will be made to practice does not recur:</p> <p>The maintenance director will be serviced by the area maintenance director prior to 7.9.15 on the preventative maintenance program and to include the standard for smoking receptacles.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>To ensure ongoing compliance with this corrective action, the Maintenance Director/designee will be responsible for completion of the Audit Tool titled, "Smoking Receptacle Safety" daily for 3 weeks and weekly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up.</p> <p>It is the practice of this facility to ensure appropriate measures are in place to promote a safe environment.</p>	07/09/2015

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	<p>provided with intake combustion air from the outside for any room containing fuel-fired equipment in accordance with LSC Section 19.5.2.2. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems to 6 residents in the 500 hall.</p> <p>Findings include:</p> <p>Based on observation and interview on 06/09/15 at 3:44 p.m., the Maintenance Supervisor confirmed the 500 hall water heater room, containing an operable gas fueled water heater, lacked a fresh air intake.</p> <p>3.1-19(b)</p>		<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>There were no specifically identified residents affected by this finding. An outside air vent will be replaced in the 500 hall water heater room by 7.9.15.</p> <p>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:</p> <p>All residents have the potential to be affected by the finding. Each of the water heater rooms in the facility will be inspected to ensure that an outside air vent is present to reduce the likelihood of a carbon monoxide rich atmosphere.</p> <p>What measures will be put into place or what systemic changes will be made so practice does not recur:</p> <p>The maintenance director will be serviced the area maintenance director prior to 7.9.15 on the preventative maintenance program and to include the routine inspection of placement and function of outside air vents in</p>		

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K 0130 SS=C Bldg. 01	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review and interview, the facility failed to ensure a battery replacement program was provided to ensure 34 of 34 single station smoke alarms would operate. This deficient practice affects 60 residents.</p> <p>Findings include:</p> <p>Based on record review and interview on 06/09/15 at 2:30 p.m., the Maintenance Supervisor acknowledged the facility did</p>	K 0130	<p>areas that could present a danger.</p> <p>Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place: To ensure ongoing compliance with thiscorrective action, the Maintenance Director/designee will be responsible for bringing information on any areasthat could benefit from air vent upgrades to the Safety Committee meetingmonthly for review. Findings will be submitted to ED for immediateresolve and as needed as well as to the the CQI Committee for review and followup.</p> <p>k-130 Itis the practice of this facility to ensure appropriate measures are in place topromote a safe environment.</p> <p>Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice:</p> <p>There were no specifically identified residents affected by</p>	07/09/2015

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	not have documentation of a replacement program for the thirty four single station smoke alarms installed in the resident rooms on the 100, 200 and 300 halls. 3.1-19(b)		<p>thisfinding. Each of the detectors in rooms in the 100,200 and 300 hall are 10 year detectors and the replacement date has been recorded for each detector and added to the preventative maintenance program.</p> <p>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:</p> <p>All residents have the potential to be affected by the finding. Documentation will be maintained with appropriate indication of a replacement date of each detector in the preventative maintenance binder.</p> <p>What measures will be put into place or what systemic changes will be made to practice does not recur:</p> <p>The maintenance director will be serviced the area maintenance director prior to 7.9.15 on the preventative maintenance program and to include maintaining documents and scheduled replacement plan for smoke detectors.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p>		

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K 0144 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on observation and interview, the facility failed to provide a functional remote generator annunciator panel for 1 or 1 emergency generators. NFPA 99, Section 3-4.1.1.15 requires a remote annunciator be provided in a location readily observable by operating personal at a regular work station. LSC 4.6.12.1 requires any device or equipment required for compliance with this Code shall thereafter be continuously maintained. LSC 9.6.1.7 says, to ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program</p>	K 0144	<p>To ensure ongoing compliance with this corrective action, the Maintenance Director/designee will be responsible for bringing the fire detector expiration schedule to the Monthly Safety Committee meeting monthly to review the timeliness of any detector replacements required. Findings will be submitted to ED for immediate resolve and as needed as well as to the the CQI Committee for review and followup.</p> <p>K-144 It is the practice of this facility to ensure appropriate measures are in place to promote a safe environment.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>There were no specifically identified residents affected by this finding. During the course of the survey the generator was placed in auto mode and a 30 minute load test was conducted for the month of June.</p>	07/09/2015

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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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	<p>complying with NFPA 72, National Fire Alarm Code. NFPA 72, 7-4.3 requires all apparatus requiring resetting to maintain normal operations shall be reset as promptly as possible after each test and alarm. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 06/09/15 at 2:45 p.m., a red light was illuminated at the generator annunciator indicating the generator was "not in auto". Based on an interview with the Maintenance Supervisor at the time of observation, he acknowledged the generator switch had not been returned to the auto position and stated he was unsure how long the generator had been in manual mode.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 2 of the last 12 months. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of</p>		<p>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:</p> <p>All residents have the potential to be affected by the finding. The maintenance director will be required to complete a monthly load test prior to the 15th of each calendar month for review as a portion of the monthly safety committee meeting.</p> <p>What measures will be put into place or what systemic changes will be made to practice does not recur:</p> <p>The maintenance director will be serviced the area maintenance director prior to 7.9.15 on the preventative maintenance program and to include adherence to the monthly generator load test required task.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>To ensure ongoing compliance with this corrective action, the Maintenance Director/designee will be responsible for bringing the monthly generator load tests to the Safety Committee meeting monthly to ensure</p>	

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K 0147	<p>NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating, whichever is greater, at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the generator log "Weekly Inspection Checklist" with the Maintenance Supervisor on 06/08/15 at 12:40 p.m., there was no documentation of a generator load test for the months of April and May 2015. At the time of record review the Maintenance Supervisor confirmed a monthly generator load test was not conducted in the aforementioned months.</p> <p>3.1-19(b)</p> <p>NFPA 101</p>		<p>completion. Findings will be submitted to ED for immediateresolve and as needed as well as to the the CQI Committee for review and followup.</p>				

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SS=D Bldg. 01	<p>LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 flexible cord power strips, 2 of 2 flexible cords such as an extension cord and 1 of 1 multiplug adapter were not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect any resident in or near the smoking shed and the medication room in the event of an emergency.</p> <p>Findings include:</p> <p>Based on an observations and interviews on 06/09/15, the Maintenance Supervisor acknowledged following:</p> <p>a) at 2:26 p.m., a refrigerator and a charger were plugged in and receiving power from a multiplug adapter in resident room 303</p> <p>b) at 3:40 p.m., a charger and a fan were plugged in and receiving power from an extension cord power strip which was plugging into and receiving power from</p>	K 0147	<p>K-147 It is the practice of this facility to ensure appropriate measures are in place to promote a safe environment.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>There were no specifically identified residents affected by this finding. The multi-plug adapter was removed from room 303 and plugged into an approved surge protector. The extension cord power strips were removed from the ADON office powering the fan and charger and replaced with a single surge protector. The extension cord providing power to the refrigerator in the medical records office was removed and replaced with a surge protector.</p> <p>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:</p> <p>All residents have the potential to be affected by the finding. The maintenance director or designee</p>	07/09/2015			

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	<p>another extension cord power strip in the ADON's office</p> <p>c) at 3:55 p.m., a refrigerator was plugged in and receiving power from an extension cord in the basement medical records office.</p> <p>3.1-19(b)</p>		<p>will inspect each area in the facility to include residentrooms, common areas and offices to identify any other multi-plug outlets orextension cords in use and will eliminate the use of these items.</p> <p>Whatmeasures will be put into place or what systemic changes will be made topractice does not recur:</p> <p>The maintenance director will beinserviced the area maintenance director prior to 7.9.15 on the preventativemaintenance program and to include monitoring of the use of multi-plug adaptersor extension cords.</p> <p>Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place:</p> <p>To ensure ongoing compliance with thiscorrective action, the Maintenance Director/designee will be responsible for completion of the Audit Tooltitled, "Extension Cords and Multi-Plug Adapters" daily for 3 weeks and weeklyfor 6 months. If threshold of 90% is not met, an action plan will be developed.Findings will be submitted to the CQI Committee for review and follow up.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

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