

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155669	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/04/2016
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NAME OF PROVIDER OR SUPPLIER RIVERVIEW TCU	STREET ADDRESS, CITY, STATE, ZIP CODE 395 WESTFIELD RD TCU NOBLESVILLE, IN 46060
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K 0000 Bldg. 01	<p>A Life Safety Code Recertification and a State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/04/16</p> <p>Facility Number: 011046 Provider Number: 155669 AIM Number: NA</p> <p>At this Life Safety Code survey, Riverview TCU 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 facility is located on the fourth floor of a fully sprinklered five story building. This facility was determined to be of Type I (332) construction. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all 13 resident sleeping</p>	K 0000	<p>Preparation and /or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and /or executed in compliance with state and federal laws.</p> <p>The plan of correction constitutes our Credible Allegation of compliance with all regulatory requirements.</p> <p>This provider requests A Desk Review in lieu of a Post Survey revisit. Our Date of compliance is:</p> <p>9/3/2016</p>	
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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 0032 SS=F Bldg. 01	<p>rooms. The facility has a capacity of 25 and had a census of 6 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review completed on 08/08/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Not less than one exit from each floor or fire section shall be a door leading outside, stair, smoke-proof enclosure, ramp, or exit passageway. Only one of these two exits may be a horizontal exit. Egress shall not return through the zone of fire origin. 18.2.4.1, 18.2.4.2, 19.2.4.1, 19.2.4.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 smoke compartments were provided with at least one exit providing a continuous path of travel to an exit discharge. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Administrator and the Manager of Engineering during a tour of the facility</p>	K 0032	<p>K 0032</p> <p>It is the practice of this provider to abide by the Life Safety Code determined appropriate for this Unit. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? This provider completed an assessment by Fire Safety Evaluation System (FSES to demonstrate equivalent</p>	09/03/2016

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K 0034 SS=F Bldg. 01	<p>from 12:25 p.m. to 1:20 p.m. on 08/04/16, the TCU has two emergency exits. One exit is a horizontal exit into the adjacent smoke compartment. The adjacent smoke compartment has two exit stairwells. The second exit is an exit stairwell which does not connect to an exit discharge directly to the exterior. Based on interview at the time of the observations, the Administrator and the Manager of Engineering acknowledged each smoke compartment is not provided with at least one exit discharging directly to the exterior of the building.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4 Based on observation and interview, the facility failed to provide a continuous protected path of travel to an exit</p>	K 0034	<p>compliance. (See attached FSES survey) How will other patients having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken · All patients located on the 4th floor have the potential to be affected by this alleged practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur FSES audit will be completed when structural changes are made to the Unit 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 The Hospital will update the FSES survey/audit when any life safety structural changes are made to this area What date the systemic changes will be completed: With acceptance of the FSES survey/audit, systemic corrections will be completed by September 3, 2016</p> <p>K 034 It is the practice of this provider to abide by the Life Safety Code determined appropriate for this Unit. What</p>	09/03/2016

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	<p>discharge for 3 of 3 exits in accordance with LSC sections 7.2.3.5. LSC 7.2.3.5 requires every smoke proof enclosure shall discharge into a public way, into a yard or court having direct access to a public way, or into an exit passageway. Such exit passageways shall be without openings other than the entrance from the smoke proof enclosure and the door to the outside yard, court, or public way. The exit passageway shall be separated from the remainder of the building by a two hour fire resistance rating. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Administrator and the Manager of Engineering during a tour of the facility from 12:25 p.m. to 1:20 p.m. on 08/04/16, the fourth floor on which the TCU is located is divided into two smoke compartments and has three stairwell exits. Additionally, the fire resistance rating of the three exit enclosures on the first floor of the hospital to the exit discharge door is less than two hours. Based on interview at the time of the observations, the Administrator and the Manager of Engineering acknowledged each of the three exit discharge passageways are not separated from the</p>		<p>corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · This provider completed an assessment by Fire Safety Evaluation System (FSES to demonstrate equivalent compliance. (See attached FSES survey) How will other patients having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken · All patients located on the 4th floor have the potential to be affected by this alleged practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur FSES audit will be completed when structural changes are made to the Unit 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 The Hospital will update the FSES survey/audit when any life safety structural changes are made to this area What date the systemic changes will be completed: With acceptance of the FSES survey/audit, systemic corrections will be completed by September 3, 2016</p>		

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K 0154 SS=C Bldg. 01	<p>remainder of the building by a two hour fire resistance rating.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period for 1 of 1 written plans in order to protect 6 of 6 residents. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, the Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice could affect all residents, staff and</p>	K 0154	<p>K 154 It is the practice of this provider to abide by the requirement for the Automatic Sprinkler System that is out of service by notifying the authorities that have jurisdiction for this unit.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · This provider updated the "Interim Life Safety Measures" polices to include notification of authorities that have jurisdiction for this unit.</p> <p>How will other patients having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <p>· All patients located on the 4th floor have the potential to be</p>	09/03/2016

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	<p>visitors.</p> <p>Findings include:</p> <p>Based on review of "Interim Life Safety Measures" documentation with the Administrator and the Manager of Engineering during record review from 9:30 a.m. to 12:25 p.m. on 08/04/16, the written fire watch policy for the facility did not notification of the Indiana State Department of Health (ISDH) which is an authority having jurisdiction. In addition, the aforementioned written fire watch policy for automatic sprinkler system impairment did not include notification of the fire alarm system monitoring company, the insurance carrier and the building owner. Based on interview at the time of record review, the Manager of Engineering stated the fire alarm system is monitored by an off-site alarm monitoring company and acknowledged the written fire watch policy did not include notification of ISDH, the fire alarm system monitoring company, the insurance carrier and the building owner.</p> <p>3.1-19(b)</p>		<p>affected by this alleged practice.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur This policy will be reviewed and changed as new regulations effect this process. 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>The Hospital will review this policy annually to insure it meets the intent of the NFPA standards</p> <p>What date the systemic changes will be completed: With acceptance of this policy systemic corrections will be completed by September 3, 2016</p>		

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K 0155 SS=C Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a complete written policy for the facility containing procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period for 1 of 1 written plans in accordance with LSC, Section 9.6.1.8 in order to protect 6 of 6 residents. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Interim Life Safety Measures" documentation with the Administrator and the Manager of Engineering during record review from 9:30 a.m. to 12:25 p.m. on 08/04/16, the written fire watch policy for the facility in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period did not include notification of the Indiana State Department of Health (ISDH) which is an authority having jurisdiction. Based on</p>	K 0155	<p>K 155 It is the practice of this provider to abide by the requirement for the Automatic Sprinkler System that is out of service by notifying the authorities that have jurisdiction for this unit.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · This provider updated the "Interim Life Safety Measures" policies to include notification of authorities that have jurisdiction for this unit.</p> <p>How will other patients having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <p>· All patients located on the 4th floor have the potential to be affected by this alleged practice.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur This policy will be reviewed and changed as new regulations effect this process. How the</p>	09/03/2016

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	interview at the time of record review, the Administrator and the Manager of Engineering acknowledged the written fire watch policy for the facility in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period did not include notification of ISDH. 3.1-19(b)		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 The Hospital will review this policy annually to insure it meets the intent of the NFPA standards What date the systemic changes will be completed: With acceptance of this policy systemic corrections will be completed by September 3, 2016		