

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155106	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  12/09/2013
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NAME OF PROVIDER OR SUPPLIER  RIVERWALK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 295 WESTFIELD RD NOBLESVILLE, IN 46060
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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: 12/09/13</p> <p>Facility Number: 000044 Provider Number: 155106 AIM Number: 100274940</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist,</p> <p>At this Life Safety Code survey, Riverwalk 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 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 and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping</p>	K010000	The creation and submissions of the 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. This Provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests desk review for paper compliance in lieu of post Life Safety survey visit on or after January 1, 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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	<p>rooms. The facility has a capacity of 184 and had a census of 145 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility has two detached buildings providing facility storage services which were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/16/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010025 SS=F	<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 1 of 1 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 10:45 a.m. to 2:45 p.m. on 12/09/13, the following openings in the ceiling smoke barrier exposed the attic above and did not provide at least a one half hour fire resistance rating:</p> <p>a. the eight inch in diameter annular space surrounding a six inch in diameter duct passing through the ceiling of the Mechanical Room by the Memory Care I Dining Room.</p> <p>b. the ten inch in diameter annular space surrounding an eight inch in diameter</p>	K010025	<p>K 0025 It is the consistent practice of this Provider to ensure smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3.I. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice.(1) a. the eight inch space surrounding a six inch in diameter duct was fixed, filled and corrected during the initial tour on Dec 9, 2013.b. the ten inch in diameter annular space surrounding the eight inch duct plus three separate one half inch holes in ceiling were fixed, filled and corrected during the initial tour on Dec 9, 2013.c. the twelve inch space surrounding a dryer duct and the space surrounding a natural pipe in laundry room ceiling was fixed, filled and corrected.d. the twelve inch in diameter space surrounding the duct in the mechanical room was</p>	01/01/2014			

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	<p>duct passing through the ceiling of the Laundry Room closet plus three separate one half inch in diameter holes in the ceiling of the aforementioned closet.</p> <p>c. the twelve inch in diameter annular space surrounding a ten inch in diameter dryer duct passing through the ceiling of the Laundry Room behind the dryers. The annular space surrounding a two inch in diameter natural gas pipe which passed through the Laundry Room ceiling behind the dryers.</p> <p>d. the twelve inch in diameter annular space surrounding a ten inch in diameter duct passing through the Mechanical Room by Room 239.</p> <p>e. a five inch by one inch opening above the "E.M. #1" panel, a one foot by two inch opening above "Panel #2" and a six inch in diameter opening for 20 cables in the ceiling of the Main Fire Panel Room. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned openings in the ceiling smoke barrier did not provide at least a one half hour fire resistance rating.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 4 attic smoke barriers was constructed to provide at least a one half hour fire resistance</p>		<p>fixed, filled and corrected on Dec 9, 2013.e. the five inch opening at the EM #1 panel and the six inch above the #2 panel were fixed, filled and corrected on Dec 9, 2013.(2) the appropriate drywall was installed and properly covered the exposed wood to the attic smoke barrier wall above the cross corridor set by room 215. This attic smoke barrier is currently in compliance with providing the proper smoke barrier.(3) a. the section of drywall in the attic smoke barrier wall above the corridor door set near room 215 was corrected, fixed and replaced.b. the two inche opening for 20 cables in the attice smoke barrier wall near room 240 was fixed and corrected.c. the two, two inch holes in the attic smoke barrier concrete block wall near room 104 was fixed and corrected.(4) the two and half inch annular space surrounding a sprinkler pipe in the mechanical room at memory Care I dining room was fixed, filled and corrected on Dec 9, 2013.II. How will other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken. Residents residing at this facility near and around these openings have the ability and potential to be affected by the alleged deficient practice. Each area identified as an alleged deficient was corrected and fixed</p>				

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	<p>rating. This deficient practice could affect at least 26 residents, staff and visitors in the vicinity of the K Hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:45 a.m. to 2:45 p.m. on 12/09/13, the entire length of the attic smoke barrier wall above the cross corridor door set by Room 215 had exposed untreated wood studs on the K Hall side of the smoke barrier wall. The opposite side of the aforementioned attic smoke barrier wall had three layers of 5/8th inch drywall attached to the exposed untreated wood studs except for a five foot by eight foot section and a ten inch in diameter section which each consisted of one layer of 5/8th inch drywall. Based on interview at the time of observation, the Maintenance Director acknowledged the exposed untreated wood studs on the K Hall side of the attic smoke barrier wall did not provide construction of at least one half hour fire resistance rating.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 3 of 4 attic smoke barriers were protected to maintain the smoke resistance of each smoke</p>		<p>on Dec 9, 2013 ensuring that this Provider continues to ensure there are smoke barriers that provide at least a one half hour of resistance rating in accordance with 8.3III. What measures will be put into place / what systemic changes will be made to ensure that the alleged deficient practice does not recur. A vendor check list will be instituted and completed by the maintenance to identify work when completed by a vendor and review any work that may have negatively effected this Provider smoke barriers, sprinkler systems, sprinkler heads A review of work completed will be checked off to identify if any smoke barriers or sprinklers have been effected near and around where work was completed. Additionally, a semi annual building walk thru will be conducted by maintenance to monitor, assess and identify effective smoke barriers and sprinkler heads. This will become a part of the maintenance preventative program.IV. How the corrective actions will be monitored to ensure the alleged deficient practice does not recur / what QA program if any are put into place. The Executive Director and Maintenance Director will monitor ongoing after each vendor completes work and semi annual building review - review and monitor this new process and program to ensure this Providers smoke barriers, spinkler system</p>				

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	<p>barrier. 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 at least 72 residents, staff and visitors if smoke from a fire were to infiltrate the protective barriers.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 10:45 a.m. to 2:45 p.m. on 12/09/13, the following openings in attic smoke barrier walls were located above corridor door sets:</p> <p>a. a one foot square section of drywall for passage of an eight inch in diameter duct was missing in the attic smoke barrier wall above the corridor door set by Room 215.</p> <p>b. a two inch in diameter opening for 20 cables and a five inch in diameter opening for 20 cables in the attic smoke barrier wall above the corridor door set by Room 240.</p> <p>c. two, two inch in diameter holes in the attic smoke barrier concrete block wall</p>		and sprinkler heads remain within compliance of the law.				

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	<p>above the corridor door set by Room 104. Each of the aforementioned penetrations in attic smoke barrier walls were not firestopped or sealed with a material for maintaining the smoke resistance of the attic smoke barrier. Based on interview at the time of the observations, the Maintenance Director acknowledged the unprotected openings in the aforementioned attic smoke barrier walls were not protected to maintain the smoke resistance of each smoke barrier.</p> <p>3.1-19(b)</p> <p>4. Based on observation and interview, the facility failed to ensure openings through 1 of 8 smoke barrier walls were protected to maintain the smoke resistance of the smoke barrier. This deficient practice could affect 5 staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:45 a.m. to 2:45 p.m. on 12/09/13, the two and a half inch annular space surrounding a two inch in diameter sprinkler pipe which passed through the wall of the Mechanical Room which abuts the Memory Care I Dining Room did not maintain the smoke resistance of the</p>			

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	<p>smoke barrier wall. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned opening in the Mechanical Room smoke barrier wall failed to maintain the smoke resistance of the smoke barrier.</p> <p>3.1-19(b)</p>			

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K010029 SS=E	<p>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 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 ensure 3 of 21 hazardous areas such as fuel fired heater rooms and the laundry were separated from other spaces by smoke resistant partitions. This deficient practice could affect 46 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 10:45 a.m. to 2:45 p.m. on 12/09/13, the following openings in the wall and ceiling smoke barriers were noted which did not separate these hazardous areas from other spaces by smoke resistant partitions:</p> <p>a. the eight inch in diameter annular space surrounding a six inch in diameter duct passing through the ceiling of the Mechanical Room by the Memory Care I</p>	K010029	<p>K 0029 It is the consistent practice of this Provider to ensure hazardous areas are separated from other spaces by smoke resistant partitions.I. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice.a. the eight inch annular space surrounding a duct passing through the ceiling in the mechanical room was fixed, filled and corrected on Dec 9, 2013.b. the ten inch annular space surrounding the duct through the ceiling of the laundry room and thre one half inch in the ceiling was fixed, filled and corrected on Dec 9, 2013.c. the twelve inche annular space surrounding the dryer duct in the laundry room behind the dryer was fixed, filled and corrected.d. the twelve inch annular space surrounding a duct passing through the ceiling in the</p>	01/01/2014			

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	<p>Dining Room which contained a natural gas fired water heater and furnace. The two and a half inch annular space surrounding a two inch in diameter sprinkler pipe which passed through the wall of the Mechanical Room which abuts the Memory Care I Dining Room.</p> <p>b. the ten inch in diameter annular space surrounding an eight inch in diameter duct passing through the ceiling of the Laundry Room closet which contained two natural gas fired water heaters. Three separate one half inch in diameter holes in the ceiling of the aforementioned closet.</p> <p>c. the twelve inch in diameter annular space surrounding a ten inch in diameter dryer duct passing through the ceiling of the Laundry Room behind the dryers. The annular space surrounding a two inch in diameter natural gas pipe which passed through the Laundry Room ceiling behind the dryers.</p> <p>d. the twelve inch in diameter annular space surrounding a ten inch in diameter duct passing through the ceiling of the Mechanical Room by Room 239 which contained one natural gas fired water heater.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned openings in the smoke barrier wall and ceiling did not not separate these hazardous areas from other spaces by</p>		<p>mechanical room near 239 was fixed, filled and corrected.II. How will other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken. Residents residing at this facility near and around these openings have the ability and potential to be affected by the alleged deficient practice. Each area identified as an alleged deficient was corrected and fixed on Dec 9, 2013 ensuring that this Provider continues to ensure there are smoke barriers that provide at least a one half hour of resistance rating in accordance with 8.3III. What measures will be put into place / what systemic changes will be made to ensure that the alleged deficient practice does not recur. A vendor check list will be instituted and completed by the maintenance to identify work when completed by a vendor and review any work that may have negatively effected this Provider smoke barriers, sprinkler system and sprinkler heads. A review of work completed will be checked off to identify if any smoke barriers have been effected near and around where work was completed. Additionally, a semi annual building walk thru will be conducted by maintenance to monitor, assess and identify effective smoke barriers, sprinkler and sprinkler heads. This will</p>				

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	smoke resistant partitions.  3.1-19(b)		become a part of the maintenance preventative program.IV. How the corrective actions will be monitored to ensure the alleged deficient practice does not recur / what QA program if any are put into place.The Executive Director and Maintenance Director will monitor ongoing after each vendor completes work and semi annual building review - review and monitor this new process and program to ensure this Providers smoke barriers remain within compliance of the law.		

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K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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 the sprinkler system was installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 5-6.3.3 states standard pendent sprinklers shall be located a minimum of 4 inches from a wall. This deficient practice could affect 22 residents, staff and visitors in C Hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:45 a.m. to 2:45 p.m. on 12/09/13, the standard pendent sprinkler in the C Hall linen closet by Room 133 was installed on the ceiling up against the back wall of the closet. Based on</p>	K010056	<p>K 0056 It is the consistent practice of this Provider to ensure the sprinkler system is installed in accordance with NFPA13.I. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice.C Hall linen closet sprinkler head was professionally moved to proper distance from the wall to be in compliance with applicable laws.II. How will other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken.All residents near and around this deficient practice have the potential to be affected by the alleged deficient practice. The sprikler head was professionally replaced and removed to proper distance from the wall to be in compliance with</p>	01/01/2014

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	<p>interview at the time of observation, the Maintenance Director acknowledged the aforementioned sprinkler location was installed on the ceiling less than four inches from a wall.</p> <p>3.1-19(b) 3.1-19(ff)</p>		<p>applicable laws.III. What measures will be put into place / what systemic changes will be made to ensure that the alleged deficient practice does not recur.A vendor check list will be instituted and completed by the maintenance to identify work when completed by a vendor and review any work that may have negatively effected this Provider smoke barriers, sprinkler system and sprinkler heads. A review of work completed will be checked off to identify if any smoke barriers have been effected near and around where work was completed. Additionally, a semi annual building walk thru will be conducted by maintenance to monitor, assess and identify effective smoke barriers, sprinkler and sprinkler heads. This will become a part of the maintenance preventative program.IV. How the corrective actions will be monitored to ensure the alleged deficient practice does not recur / what QA program if any are put into place.The Executive Director and Maintenance Director will monitor ongoing after each vendor completes work and semi annual building review - review and monitor this new process and program to ensure this Providers smoke barriers remain within compliance of the law.</p>		

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K010062 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to replace 5 of over 100 sprinklers in the facility which had become corroded, had paint, lint or other foreign materials on them. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 72 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 10:45 a.m. to 2:45 p.m. on 12/09/13, the following automatic sprinkler locations each had become corroded or had paint, lint or other foreign materials on them:</p> <p>a. C Hall shower room.</p>	K010062	<p>K 0062 It is the consistent practice of this Provider to ensure the automatic sprinkler system be inspected, tested and maintained in accordance with NFPA25.1. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice.a. C Hall shower room sprinkler head was replacedb. Memory Care II shower room sprinkler was replacedc. Nusing supply room sprinkler was replacedd. K hall shower room was replacede. Laundry room behind dryer spinkler was replaced.II. How will other residents having the potential to be affectged by the same alleged deficient practice will be identified and what corrective action will be taken. Residents residing at this facility near and around these sprinklers have the ability and potential to be affected by the alleged deficient practice. Each area identified as an alleged deficient was corrected by replacement of sprinkler ensuring that this Provider continues to ensure there are properly working sprinkler heads, testing and operation within applicable laws. III. What measures will be</p>	01/01/2014
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155106		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 12/09/2013	
NAME OF PROVIDER OR SUPPLIER  RIVERWALK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 295 WESTFIELD RD NOBLESVILLE, IN 46060			
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	<p>b. sprinkler above the entry door to the Memory Care II shower room.</p> <p>c. Nursing Supply Room.</p> <p>d. K Hall shower room.</p> <p>e. behind the dryers in the Laundry Room.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned automatic sprinklers had become corroded or had paint, lint or other foreign materials on them.</p> <p>3.1-19(b)</p>		<p>put into place / what systemic changes will be made to ensure that the alleged deficient practice does not recur. A vendor check list will be instituted and completed by the maintenance to identify work when completed by a vendor and review any work that may have negatively effected this Provider smoke barriers, sprinkler system and sprinkler heads. A review of work completed will be checked off to identify if any smoke barriers have been effected near and around where work was completed. Additionally, a semi annual building walk thru will be conducted by maintenance to monitor, assess and identify effective smoke barriers, sprinkler and sprinkler heads. This will become a part of the maintenance preventative program.IV. How the corrective actions will be monitored to ensure the alleged deficient practice does not recur / what QA program if any are put into place. The Executive Director and Maintenance Director will monitor ongoing after each vendor completes work and semi annual building review - review and monitor this new process and program to ensure this Providers smoke barriers remain within compliance of the law.</p>				