

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155165	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/21/2014
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NAME OF PROVIDER OR SUPPLIER RIVERVIEW VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129
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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: 03/21/14</p> <p>Facility Number: 000082 Provider Number: 155165 AIM Number: 100289640</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Riverview 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 two story facility was determined to be of Type II (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection on all levels including in the corridors, in spaces open to the corridors and battery operated smoke detectors in all resident sleeping</p>	K010000	I respectfully request paper compliance related to the deficiencies cited in this survey. Thank you.	
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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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	<p>rooms. The facility has a capacity of 130 and had a census of 105 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled. All areas providing facility services were sprinkled except the detached laundry building.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/27/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			
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K010027 SS=E	<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 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 3 of 8 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect 44 residents who reside on the A Hall, D Hall and Cottage Hall.</p> <p>Findings include:</p> <p>Based on observations on 03/21/14 during a tour of the facility from 9:30 a.m. to 12:35 p.m. with the administrator and maintenance supervisor, the D Hall, A Hall and Cottage Hall sets of smoke</p>	K010027	<p>K - 027 The facility does ensure smoke barrier doors restrict the movement of smoke for at least 20 minutes.1. 3 of 8 smoke barrier doors located on D hall, A hall and Cottage hall were adjusted to ensure they closed properly leaving only the minimum clearance of 1/8" for proper operation per the standard.2. All residents have the potential to be affected. 100% audit completed of all smoke barrier doors by Maintenance Director on 4/4/14 to determine proper closing.3. Maintenance Director re-educated on proper standard of smoke barrier doors by CEC on 4/4/14. Maintenance will check all smoke barrier doors for proper closure weekly.4. To ensure compliance, the Housekeeping/Laundry Supervisor/designee will complete the Life Safety CQI tool monthly times 6 months and then quarterly until compliance is</p>	04/11/2014			

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	barrier doors each had a gap one half inch to one inch wide where the door sets met in the closed position. This was verified by the administrator and maintenance supervisor at the time of observations and acknowledged at the exit conference on 03/21/14 at 12:45 p.m. 3.1-19(b)		maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to ensure compliance.		

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K010038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 5 exit doors with delayed egress locks released within 15 seconds after pressure was applied to the releasing device. LSC 7.2.1.6.1, Delayed Egress Locks allows approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided:</p> <p>(a) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6.</p> <p>(b) The doors unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon</p>	K010038	<p>K 038 - The facility does ensure that exit doors with delayed egress locks release within 15 seconds after pressure is applied to the releasing device.1. 1 of 5 exit doors on C hall with delayed egress locks repaired by an outside contractor on 3/23/14.2. All residents have the potential to be affected. 100% audit completed of all exit doors with delayed egress locks by the Maintenance Director on 4/5/14 to determine proper functioning.3. Maintenance Director re-educated on proper standard of exit doors with delayed egress locks by the CEC on 4/5/14. Maintenance Director will check all exit doors with delayed egress locks weekly.4. To ensure compliance, the Housekeeping/Laundry Supervisor/designee will complete the Life Safety CQI tool monthly times 6 months and then quarterly until compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to ensure compliance.</p>	04/11/2014			

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	<p>application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only.</p> <p>Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS".</p> <p>This deficient practice could affect 14 residents who reside on the C Hall and would use the C Hall exit door during an evacuation.</p> <p>Findings include:</p> <p>Based on observation on 03/21/14 at 10:55 a.m. with the administrator and maintenance supervisor, the C Hall exit door was provided with a sign stating Push Until Alarm Sounds, Door Can Be Opened In 15 Seconds. Pressure was</p>			
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	<p>applied to the releasing device for over fifteen seconds on three attempts and the door's magnetic lock failed to release. This was verified by the maintenance supervisor and administrator at the time of observation and acknowledged by the administrator at the exit conference on 03/21/14 at 12:45 p.m.</p> <p>3.1-19(b)</p>			
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K010143 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage/transfer locations was provided with mechanical ventilation. This deficient practice does not affect any residents because the oxygen storage room was located in the Service Hall which is a staff only location.</p> <p>Findings include:</p> <p>Based on observation on 03/21/14 at 11:15 a.m. with the administrator and maintenance supervisor, the Service Hall oxygen storage room, where six full liquid oxygen containers were stored, had an exhaust fan located on the outside wall, however, the exhaust fan was not operational. Based on an interview with</p>	K010143	K 143 - The facility does ensure that oxygen storage/transfer location is provided with mechanical ventilation.1. The exhaust fan in the oxygen storage/transfer location replaced and is operating properly. The facility has only one oxygen storage/transfer location.2. All residents have the potential to be affected. The oxygen storage/transfer location was assessed and it was determined that the means of mechanical ventilation was to be replaced by the Maintenance Director.3. Maintenance Director re-educated on proper oxygen storage operations by the CEC on 4/5/14. Maintenance Director will check functionality of the exhaust fan in the oxygen storage/transfer location weekly.4. To ensure	04/11/2014			

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	<p>the administrator on 03/21/14 at 11:20 a.m., the liquid oxygen storage room is used for the storage of liquid oxygen and used as a transferring location by the nursing staff. The liquid oxygen storage room exhaust fan not being operational was verified by the administrator and maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 03/21/14 at 12:45 p.m.</p> <p>3.1-19(b)</p>		<p>compliance, the Housekeeping/Laundry Supervisor/designee will complete the Life Safety CQI tool monthly times 6 months and then quarterly until compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to ensure compliance.</p>	