

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 07/12/2013
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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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K010000	<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 Dates: 07/11/13 & 07/12/13</p> <p>Facility Number: 011046 Provider Number: 155669 AIM Number: NA</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</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 building except for the elevator machine rooms for Elevators 1, 2, 3, 4 and 8. This facility was determined to be of Type I (332) construction. The facility has a fire alarm system with smoke detection in the</p>	K010000	<p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or 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. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our overall date of compliance is: 11/11/2013</p>	

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>corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all 13 resident sleeping rooms. The facility has a capacity of 25 and had a census of 16 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered except for the elevator machine rooms for Elevators 1, 2, 3, 4 and 8.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 07/17/13.</p>				

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K010032 SS=F	<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. Only one of these two exits may be a horizontal exit. 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 Engineering Manager during a tour of the facility from 9:30 a.m. to 11:40 a.m. on 07/12/13, 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 that does not connect to an exit discharge directly to the exterior. Based on interview at the time of the observations, the Administrator and the Engineering Manager acknowledged each smoke compartment is not provided with at least one exit discharging directly to the exterior of the building.</p>	K010032	<p>K 032 It is the practice of this Unit to abide by the Life Safety Code determined appropriate for this Unit.</p> <p>1. What corrective action(s) will be accomplished for those patients found to have been affected by the deficient practice;</p> <p>This provider completed an assessment by Fire Safety Evaluation System (FSSES) to demonstrate equivalent compliance.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken;</p> <p>All residents located on the 4 th floor have the potential to be affected this alleged practice.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p>	08/01/2013			

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	3.1-19(b)		<p>Systemic changes include Quality Assurance environmental tours will be conducted to evaluate the safety of these exits.</p> <p>FSES audit will be completed when structural changes are made to this Unit.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur,</p> <p>The Administrator and or designee will audit safety inspection forms for these stairwell exits to determine safe means of egress 2 times per week for 30 days than 2 times per month for 150 days than 1 time per month for 180 days to total 12 months of monitoring. Results of the audits will be reported to QA monthly for 12 months. After 100% compliance is reached the QA committee will determine the frequency of continued monitoring.</p> <p>The Hospital will up dated FSES survey when any life safety structural changes are made to this area.</p> <p>5. What date the systemic changes will be completed.</p>		

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			These systemic changes will be completed by 8/01/2013	

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K010034 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4</p> <p>Based on observation and interview, the facility failed to provide a continuous protected path of travel to an exit discharge for 3 of 3 exits in accordance with LSC sections 7.2.3.5. LSC 7.2.3.5 requires every smokeproof 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 smokeproof 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 Engineering Manager during a tour of the facility from 9:30 a.m. to 11:40 a.m. on 07/12/13, 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</p>	K010034	<p>K 034 It is the practice of this Provider to abide by the Life Safety Code determined appropriate for this Unit.</p> <p>1. What corrective action(s) will be accomplished for those patients found to have been affected by the deficient practice;</p> <p>This provider completed an assessment by Fire Safety Evaluation System (FSSES) to demonstrate equivalent compliance.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken;</p> <p>All residents located on the 4 th floor have the potential to be affected this alleged practice.</p>	08/01/2013			

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	<p>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 Engineering Manager acknowledged each of the three exit discharge passageways are not separated from the remainder of the building by a two hour fire resistance rating.</p> <p>3.1-19(b)</p>		<p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <p>Systemic changes include Quality Assurance environmental tours will be conducted to evaluate the safety of these exits.</p> <p>FSES audit will be completed when structural changes are made to this Unit.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur,</p> <p>The Administrator and or designee will audit safety inspection forms for these stairwell exits to determine safe means of egress 2 times per week for 30 days than 2 times per month for 150 days than 1 time per month for 180 days to total 12 months of monitoring. Results of the audits will be reported to QA monthly for 12 months. After 100% compliance is reached the QA committee will determine the frequency of continued monitoring.</p>	

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			<p>The Hospital will up dated FSES survey when any life safety structural changes are made to this area.</p> <p>5. What date the systemic changes will be completed.</p> <p>These systemic changes will be completed by 8/01/2013</p>		

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K010056 SS=F	<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 provide sprinkler coverage for 3 of 3 elevator machine rooms for the TCU. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be of ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon or prior to the application of water from the sprinkler located in the elevator machine room. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the</p>	K010056	<p>K 056 It is the practice of this provider to abide by NFPA 13 and provide Sprinkler System to insure complete coverage for all portions of the building that the patients from the TCU have Customary Access to. 1. What corrective action(s) will be accomplished for those patients found to have been affected by the deficient practice; Sprinkler system will be added to elevator machine rooms that service the TCU. Since this is such a large project we would like to propose the following time table. · 8/11/2013 - Plan and design work for this project completed · 9/11/2013 – Electrical component installation completed · 10/11/2013 – Elevator and Fire Alarm upgrades completed · 11/11/2013 – Sprinkler</p>	11/11/2013			

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	<p>Administrator and the Engineering Manager during a tour of the facility from 9:30 a.m. to 11:40 a.m. on 07/12/13, the elevator machine room for Elevators #1 and #2 servicing the TCU and the elevator machine room for Elevators #3 and #4 servicing the adjoining fourth floor smoke compartment were each not provided with automatic sprinklers. Based on interview at the time of the observations, the Administrator and the Engineering Manager stated comprehensive care residents have customary access to the aforementioned elevators and acknowledged the aforementioned elevator machine rooms were not provided with automatic sprinklers. Based on telephone interview with the Administrator at 3:30 p.m. on 07/12/13, the Administrator stated comprehensive care residents also have customary access to Elevator #8 in the TCU and acknowledged the elevator machine room for Elevator #8 is not provided with automatic sprinklers.</p> <p>3.1-19(b) 3.1-19(ff)</p>		<p>installation completed Total project completion by 11/11/2013 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken; All residents located on the 4 th floor have the potential to be affected this alleged practice because patients have customary access to areas covered by these machine rooms. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Systemic changes include Annual Sprinkler tests will be conducted to evaluate the safety and function of the total sprinkler system. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, Once these elevator mechanical rooms have sprinklers installed they will be included in the sprinkler inspections that are completed per regulation. The Engineering Director or designee will audit sprinkler safety inspections to insure that sprinkler system is functioning to standard. These audits will be completed at least annually following the completion of this project. The results of the audits will be reported to QA committee</p>				

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			<p>annually and reviewed by Safety Committee. After 100% compliance is reached the QA committee will determine the frequency of continued monitoring. 5. What date the systemic changes will be completed. These systemic changes will be completed per the above timeline with total project completion of 11/11/2013. Request for Waiver of completion date included in attachments</p>		

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K010067 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on record review, observation and interview; the facility failed to ensure 8 of 8 fire dampers in the facility were inspected and provided necessary maintenance at least every six years in accordance with the Centers for Medicare & Medicaid Services (CMS) Survey and Certification Group Memo S&C-10-04-LSC dated 10/30/09. Pursuant to Centers for Medicare & Medicaid Services (CMS) Survey and Certification Group Memo S&C-10-04-LSC dated 10/30/09, hospitals may operate under the six year damper testing cycle of the 2007 edition of NFPA 80, Standard for Fire Doors and Other Opening Protectives without special application to CMS. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Riverview Hospital Fire Damper" documentation dated December 2006 and Artekna's "Master Plan - Fourth Level" floor plan documentation with the Administrator</p>	K010067	<p>K 067 It is the practice of this provider to abide by NFPA 101 and ensure that fire dampers in the facility are inspected and provided necessary maintenance at least every six years in accordance with the Centers for Medicare & Medicaid Services.</p> <p>1. What corrective action(s) will be accomplished for those patients found to have been affected by the deficient practice; Fire dampers are being inspected with damper maintenance provided if needed.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken; All residents located on the 4 th floor have the potential to be affected this alleged practice because patients have customary access to areas covered by these fire dampers identified in the Fourth Floor Master Plan.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Systemic changes include this inspection will be added to the</p>	08/10/2013			

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	and the Engineering Manager during record review from 9:30 a.m. to 12:15 p.m. on 07/11/13, documentation of testing performed for eight fire dampers in the TCU within the last six years was not available for review. Artekna's "Master Plan - Fourth Level" floor plan identified eight fire dampers in the TCU as #26 through #33. "Riverview Hospital Fire Damper" documentation dated December 2006 stated fire dampers #26 through #33 were on the fourth floor of the facility and were inspected in December 2006. Based on interview at the time of record review, the Administrator and the Engineering Manager stated no other fire damper inspection documentation was available for review and acknowledged it had been more than six years since the most recent testing of the aforementioned fire dampers was performed. Based on observations with the Administrator and the Engineering Manager during a tour of the facility from 9:30 a.m. to 11:40 a.m. on 07/12/13, fire damper #28 and fire damper #31 were observed, respectively, in the HVAC system for the TCU in Room 455 and in the Lounge. Based on interview at the time of the observations, the Administrator and the Engineering Manager acknowledged fire dampers were installed at the aforementioned locations.		preventative maintenance calendar every six years, per regulation. This information will be included in Quality Assurance Committee/Safety Committee annual review. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, The Director of Engineering or designee will update preventive maintenance schedule to include Fire Damper inspections/maintenance per regulation or at least every six years. Results of these inspections will be reported to QA committee /Safety Committee during annual review. After 100% compliance is reached the QA committee will determine the frequency of continued monitoring. 5. What date the systemic changes will be completed. These systemic changes will be completed by 8/10/2013. See the attached inspection report from Bright Sheet Metal.				

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K010069 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure 2 of 2 hood extinguishing systems in the kitchen were inspected and serviced every six months. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 8-2 requires an inspection and servicing of the fire extinguishing system at least every six months. This deficient practice could affect five staff and visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on a review of Koorsen Fire & Security "Restaurant Systems Work Order" documentation dated 09/18/12 with the Administrator and the Engineering Manager during record review from 9:30 a.m. to 12:15 p.m. on 07/11/13, documentation of a semiannual kitchen hood extinguishing system service record after 09/18/12 was not available for review. Based on interview at the time of record review, the Administrator and the Engineering Manager acknowledged a semiannual kitchen hood extinguishing system service record after 09/18/12 was not available for review.</p>	K010069	<p>K 069 It is the practice of this provider to abide by NFPA 96 and provide documentation of semi-annual kitchen hood extinguishing system service.</p> <p>1. What corrective action(s) will be accomplished for those patients found to have been affected by the deficient practice;</p> <p>Koorsen's Fire & Security completed the service of the dietary hood system on 7/15/2013.</p> <p>See attach inspection /service records for the dietary hood system.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken;</p> <p>All residents located on the 4 th floor have the potential to be affected this alleged practice because 4 th floor TCU is located in the same building as the Kitchen for the Hospital.</p>	08/01/2013			

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	3.1-19(b)		<p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <p>Systemic changes include Quality Assurance/ Safety Committee semiannual review of the dietary hood system service report.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur,</p> <p>The Engineering Director or designee will audit safety inspections for the kitchen hood extinguishing system per regulation but at least semiannually. These audits will be added to the preventive maintenance calendar and completed every six months. The results of the audits will be reported to QA committee/Safety Committee semiannually for 12 months. After 100% compliance is reached the QA committee will determine the frequency of continued monitoring.</p> <p>5. What date the systemic</p>		

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			changes will be completed. These systemic changes will be completed by 8/01/2013	

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K010160 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD All existing elevators, having a travel distance of 25 ft. or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.3.2</p> <p>Based on observation and interview, the facility failed to ensure the elevator equipment in 3 of 3 elevator equipment rooms for the TCU was provided with a shunt trip. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon or prior to the application of water from the sprinkler located in the elevator machine room. This deficient practice could affect all residents, staff and visitors in Elevators 1, 2, 3, 4 and 8 servicing the TCU if the sprinkler system was activated in the elevator equipment rooms.</p> <p>Findings include:</p> <p>Based on observations with the Administrator and the Engineering Manager during a tour of the facility from 9:30 a.m. to 11:40 a.m. on 07/12/13, the elevator machine room for Elevators #1 and #2 servicing the TCU and the elevator machine room for Elevators #3 and #4</p>	K010160	<p>K 160 It is the practice of this provider to abide by NFPA 101 Firefighter's service Requirements regarding Safety Code for Existing Elevators were Shunt Trip switches are applied to the elevator equipment. 1. What corrective action(s) will be accomplished for those patients found to have been affected by the deficient practice; Shunt Trip device will be added to elevator systems that service the TCU. Since this is such a large project we would like to propose the following time table. · 8/11/2013 - Plan and design work for this project completed · 9/11/2013 – Electrical component installation completed · 10/11/2013 – Elevator and Fire Alarm upgrades completed- 11/11/2013 - Sprinkler installation complete Total work to be completed by 11/11/2013 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken; All</p>	11/11/2013			

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	<p>servicing the adjoining fourth floor smoke compartment were not provided with sprinkler protection and no evidence of shunt trip installation was noted. Based on interview at the time of the observations, the Administrator and the Engineering Manager stated comprehensive care residents have customary access to the aforementioned elevators and acknowledged the aforementioned elevator machine rooms were not provided with a shunt trip. Based on telephone interview with the Administrator at 3:30 p.m. on 07/12/13, the Administrator stated comprehensive care residents also have customary access to Elevator #8 in the TCU and acknowledged the elevator machine room for Elevator #8 is not provided with a shunt trip.</p> <p>3.1-19(b)</p>		<p>residents located on the 4 th floor have the potential to be affected this alleged practice because patients have customary access to areas covered by these elevators. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Systemic changes include Annual Elevator inspections will be conducted to evaluate the safety of these elevators once this device has been installed. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, Once the Shunt Trip device has been installed they will be included with sprinkler inspections and Elevator inspections that are completed per regulation. The Engineering Director or designee will audit sprinkler safety inspections and Elevator inspections to insure that Shunt Trip device is functioning to standard. These audits will be completed per regulation but at least annually. The results of the audits will be reported to QA committee/Safety Committee annually after completion of this project. After 100% compliance is reached the QA committee will determine the frequency of continued monitoring. 5. What date the</p>				

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			systemic changes will be completed. These systemic changes will be completed by 11/11/2013, Request Waiver for completion date included in attachments.		