

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  04/02/2015
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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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K 000  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: 04/02/15</p> <p>Facility Number: 000082 Provider Number: 155165 AIM Number: 100289640</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 the corridors, spaces open to the corridors and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 130 and had a census of 107 at the time of this visit.</p>	K 000	The creation and submission of the Plan of Correction doesnot constitute an admission by this provider of any conclusion set forth in thestatement of deficiencies, or any violation of regulation. This provider respectfully requests that the 2567 Plan ofCorrection be considered the Letter of Credible Allegation and requests a DeskReview in lieu of a Post Survey Review on or after May 3, 2015.	
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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 025 SS=E Bldg. 01	<p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except the detached laundry building.</p> <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>Based on observations and interview, the facility failed to ensure the smoke barriers in 1 of 1 ceiling and 4 of 146 room walls were constructed to provide at least a one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable 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 affects 16 residents who reside on the F Hall and 15 residents who reside on the D Hall.</p>	K 025	<p>K 025</p> <p>1.What corrective action(s) will be accomplishedfor those residents found to have been affected by the deficient practice? There were no residents cited inregard to this regulation.</p> <p>1.How will you identify other residents having thepotential to be affected by the same deficient practice and what correctiveaction will be taken? Residents who reside on the F Halland residents who reside on the D Hall have the potential to be affected. Walland ceiling penetrations have been firestopped and drywall has been repaired.</p> <p>1.What measures will be put into place or whatsystemic</p>	05/02/2015

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	<p>Findings include:</p> <p>Based on observations with the maintenance supervisor during a tour of the facility on 04/02/15 from 9:40 a.m. to 1:00 p.m., the following locations had ceiling and wall penetrations not firestopped or had missing drywall;</p> <ol style="list-style-type: none"> <li>1. The maintenance office ceiling had a four foot by four foot area of drywall damaged and water stained and the drywall was separating from the ceiling and crumbling.</li> <li>2. The maintenance office bathroom south wall had two, one foot by one foot areas of drywall missing and a four inch by four inch area of drywall missing behind the door.</li> <li>3. The central supply room ceiling had a one half inch gap extending eight feet where the drywall tape was missing and two sheets of drywall came together.</li> <li>4. The F Hall soiled linen room had a one foot by six inch area of drywall missing behind the door.</li> <li>5. The employee break room north wall had a three inch diameter area of drywall missing behind the door.</li> <li>6. The D Hall east wall behind the smoke barrier door had a one foot by six inch area of drywall missing.</li> <li>7. The housekeeping room ceiling had two four foot by two foot areas of drywall</li> </ol>		<p>changes will you make to ensure that the deficient practice does notoccur?</p> <p>Maintenance Director inserved byExecutive Director on 4/3/15 the importance of maintaining the integrity ofsmoke barriers. Wall and ceiling penetrations have been firestopped and drywallhas been repaired.</p> <p>1.How will the corrective action be monitored toensure the deficient practice does not recur, i.e, what quality assuranceprogram will be put into place?</p> <p>An environmental CQI tool wil beutilized weekly X 4 and monthly thereafter to monitor compliance with ceilingor wall penetration. The CQI Committee reviews the audits and action plans aredeveloped to improve performance and determine the need for further action.</p> <p>Compliance Date: May 2, 2015</p>	
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K 029 SS=E Bldg. 01	<p>missing. The above listed areas missing drywall and not fire stopped was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 04/02/15 at 1:20 p.m.</p> <p>3.1-19(b)</p> <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 the corridor door to 2 of 14 hazardous areas, such as combustibile storage rooms over 50 square feet, were provided with self closing devices which would cause the doors to automatically close and latch into the door frames. This deficient practice could affect 15 residents who reside on the D Hall.</p>	K 029	<p>K 029</p> <p>1.What corrective action(s) will be accomplishedfor those residents found to have been affected by the deficient practice? There were no residents cited inregard to this regulation.</p> <p>1.How will you identify other residents having thepotential to be affected by the same deficient practice and what correctiveaction will be taken? Residents who reside on the D Hallhave the potential to be</p>	05/02/2015			

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K 050 SS=F Bldg. 01	<p>Findings include:</p> <p>Based on observations on 04/02/15 during a tour of the facility with the maintenance supervisor from 9:40 a.m. to 1:00 p.m., the D Hall central supply room and D Hall staffing central supply room, which measured three hundred square feet and stored combustible paper and plastic supplies, and plastic adult briefs, each had a door with a self closing device which failed to self close and latch each door into the door frames. Furthermore, the doors each had a two inch gap. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 04/02/15 at 1:20 p.m.</p> <p>3.1-19(b)</p> <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</p>		<p>affected. The self-closing devices were adjusted to close and latch properly into the door frames.</p> <p>1. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not occur?</p> <p>Maintenance Director in-serviced by Executive Director on 4/3/15 to the importance of ensuring self-closing doors latch properly into the door frames.</p> <p>1. How will the corrective action be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place?</p> <p>An environmental CQI tool will be utilized weekly X 4 and monthly thereafter to monitor compliance with ceiling or wall penetration. The CQI Committee reviews the audits and action plans are developed to improve performance and determine the need for further action.</p> <p>Compliance Date: May 2, 2015</p>		

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	<p>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 on 1 of 3 shifts for 2 of 4 quarters over the past year. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of Monthly Fire Drill Records with the maintenance supervisor on 04/02/15 at 9:40 a.m., there was no fire drill record for the second shift, first quarter of the year 2015 and second shift fourth quarter for the year 2014. Additionally, based on interview with the maintenance supervisor during the review of the Monthly Fire Drill Records, there was no other documentation available for review to verify these drills were conducted. This was verified by the maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 04/02/15 at 1:20 p.m.</p> <p>3.1-19(b)</p>	K 050	<p>K 050</p> <p>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>There were no residents cited in regard to this regulation.</p> <p>1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents, staff and visitors have the potential to be affected by the alleged deficient practice.</p> <p>1.What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not occur?</p> <p>Maintenance Director in-serviced by Executive Director on 4/3/15 on the importance of conducting fire drills under varying conditions, at least quarterly on each shift. The Executive Director or designee will review and sign off on the fire drill report quarterly.</p> <p>1.How will the corrective action be monitored to ensure the deficient practice does not recur, i.e, what quality assurance program will be put into place?</p> <p>An environmental CQI tool will be utilized quarterly to monitor compliance with fire drill reports to achieve a threshold of 100%. The CQI Committee reviews the audits and</p>	05/02/2015	

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K 052 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>1. Based on record review and interview, the facility failed to ensure 52 of 52 smoke detectors are maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, at 7-3.2.1 states, "Detector sensitivity shall be checked within one year after installation and every alternative year thereafter. After the second required calibration test, if sensitivity tests indicate the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests may be extended to a maximum of five years. If the frequency is extended, records of detector caused nuisance alarms shall be maintained. In zones or areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked</p>	K 052	<p>action plans are developed to improve performance and determine the need for further action. Compliance Date: May 2, 2015</p> <p>K 052 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? There were no residents cited in regard to this regulation. 1. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents, staff and visitors have the potential to be affected by the alleged deficient practice. 1. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not occur? Maintenance Director in-serviced by Executive Director on 4/3/15 the importance of ensuring smoke detector sensitivity is checked within one year after installation and every alternate year thereafter.</p>	05/02/2015

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	<p>sensitivity range it shall be tested using the following methods:</p> <ol style="list-style-type: none"> <li>(1) Calibrated test method.</li> <li>(2) Manufacturer's calibrated sensitivity test instrument.</li> <li>(3) Listed control equipment arranged for the purpose.</li> <li>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its acceptable sensitivity range.</li> <li>(5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction.</li> </ol> <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced.</p> <p>The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector. NFPA 72, 7-5.2 requires inspection, testing and maintenance reports be provided for the owner or a designated representative. It shall be the responsibility of the owner to maintain these records for the life of the system and to keep them available for examination by the authority having jurisdiction.</p> <p>This deficient practice affects all residents, staff and all visitors in the facility.</p>		<p>In addition, manual fire alarm pull stations boxes must be maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code.</p> <p>1. How will the corrective action be monitored to ensure the deficient practice does not recur, i.e, what quality assurance program will be put into place?</p> <p>An environmental CQI tool will be utilized monthly X 6 and quarterly thereafter to monitor compliance with testing and maintaining a fire alarm system in accordance with NFPA 70 National Electric Code and NFPA 72. The CQI Committee reviews the audits and action plans are developed to improve performance and determine the need for further action.</p> <p>Compliance Date: May 2, 2015</p>	

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	<p>Findings include:</p> <p>Based on record review on 04/02/15 at 9:50 a.m. with the maintenance supervisor, the most recent Sensitivity Test Report for fifty two smoke detectors from Integrated Electronics Inc. was dated 02/01/13, which is a period exceeding the two year testing requirement. Based on an interview with the maintenance supervisor on 04/02/15 at 10:00 a.m., there were no other records available to verify a two year sensitivity test was conducted on fifty two smoke detectors throughout the facility. The lack of a two year sensitivity test on fifty two smoke detectors was verified by the maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 04/02/15 at 1:20 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure 1 of 15 manual fire alarm pull station boxes was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the</p>			
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	<p>authority having jurisdiction. Table 7-3.2 shall apply. Table 7-3.2 "Testing Frequencies" requires alarm initiating devices, alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the most recent fire alarm system component testing report from Vanguard Alarm Services dated 11/24/14, which occurred on 04/02/15 at 10:05 a.m. with the maintenance supervisor, the report listed one of fifteen manual pull station boxes which failed to cause an alarm response to the fire alarm panel and the report did not list the location of the manual pull station box. Furthermore, there was no evidence of follow up action from the documentation provided for review from the facility. Based on an interview with the maintenance supervisor on 04/02/15 at 10:10 a.m. it was stated the manual pull station box has not been repaired. This was acknowledged by the administrator at the exit conference on 04/02/15 at 1:20 p.m.</p> <p>3.1-19(b)</p>			

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K 062 SS=F Bldg. 01	<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 record review and interview, the facility failed to ensure 1 of 1 sprinkler system components was repaired or replaced after a quarterly inspection was conducted. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements.</p> <p>Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1-8 requires records of inspections and tests of the sprinkler system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on sprinkler system record review with the maintenance supervisor on 04/02/15 at 10:10 a.m., the quarterly sprinkler system inspection report dated 08/25/14 from Vanguard Alarm Services</p>	K 062	<p>K 062</p> <p>1.What corrective action(s) will be accomplishedfor those residents found to have been affected by the deficient practice? There were no residents cited inregard to this regulation.</p> <p>1.How will you identify other residents having thepotential to be affected by the same deficient practice and what correctiveaction will be taken? All residents have the potential to beaffected by the alleged deficient practice.</p> <p>1.What measures will be put into place or whatsystemic changes will you make to ensure that the deficient practice does notoccur? Maintenance Director in-serviced byExecutive Director on 4/3/15 the importance of ensuring required automaticsprinkler systems are continuously maintained in reliable operating conditionand are inspected and tested periodically.</p> <p>1.How will the corrective action be monitored toensure the deficient practice does not recur, i.e, what quality assuranceprogram will be put into place? An environmental CQI tool will</p>	05/02/2015

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K 130 SS=E Bldg. 01	<p>indicated a failed sprinkler system water flow switch not reporting to the fire alarm panel. Furthermore, there were no other records available for review to indicate the first floor sprinkler system water flow switch was either repaired or replaced. Based on an interview with the maintenance supervisor on 04/02/15 at 10:15 a.m., the first floor sprinkler system water flow switch has not been repaired. This was acknowledged by the administrator at the exit conference on 04/02/15 at 1:20 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review and interview, the facility failed to ensure 1 of 3 hot water heater/boilers had an inspection certificate that was current to ensure the boiler was in safe operating condition. NFPA 101, in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect 62 residents who reside on the first floor near the boiler room.</p> <p>Findings include:</p>	K 130	<p>beutilized monthly X 6 and quarterly thereafter to monitor compliance withtesting and maintaining automatic sprinkler system in accordance with NFPA 25.The CQI Committee reviews the audits and action plans are developed to improveperformance and determine the need for further action. Compliance Date: May 2, 2015</p> <p>K 130</p> <p>1.What corrective action(s) will be accomplishedfor those residents found to have been affected by the deficient practice? There were no residents cited inregard to this regulation.</p> <p>1.How will you identify other residents having thepotential to be affected by the same deficient practice and what correctivaction will be taken? This alleged deficient practicecould affect 62 residents who reside on the first floor near the boiler room.</p> <p>1.What measures will be put into place or what systemicchanges will you make to ensure that the deficient practice</p>	05/02/2015

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  04/02/2015	
NAME OF PROVIDER OR SUPPLIER  RIVERVIEW VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129			
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K 144 SS=F Bldg. 01	<p>Based on review of the one A O Smith model hot water heater inspection certificate with the maintenance supervisor on 04/02/15 at 12:15 p.m., the inspection certificate for hot water heater #305030 had an expiration date of 07/21/13. Based on an interview with the maintenance supervisor on 04/02/15 at 12:20 p.m., it was stated there is no current two year inspection certificate for the A O Smith model hot water heater. The lack of current inspection certificate for the A O Smith model hot water heater was verified by the maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 04/02/15 at 1:20 p.m.</p> <p>3.1-19(b)</p> <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. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for 9 of 52 weeks over the past year over the past year were available for review. Chapter</p>	K 144	<p>does not occur? Maintenance Director in-serviced by Executive Director on 4/3/15 to the importance of ensuring inspection of the boiler to prove the boiler was in safe operating condition. Current certificate has been found and is to be displayed in boiler room with a copy kept in Maintenance Director's office. 1. How will the corrective action be monitored to ensure the deficient practice does not recur, i.e, what quality assurance program will be put into place? An environmental CQI tool will be utilized monthly X 6 and quarterly thereafter to monitor compliance with testing and maintaining automatic boiler system in accordance with NFPA 101. The CQI Committee reviews the audits and action plans are developed to improve performance and determine the need for further action. Compliance Date: May 2, 2015</p> <p>K 144 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? There were no residents cited in regard to this regulation.</p>	05/02/2015			

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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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	<p>3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. 6-4.1 requires Level 1 and Level 2 EPSS, including all appurtenant components, shall be inspected weekly and shall be exercised under load monthly at a minimum. 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 by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review of the Emergency Generator Weekly Inspection Log with the maintenance supervisor on 04/02/15 at 10:15 a.m., there was no record of weekly inspections including storage battery tests for the generator set for the first and third weeks of March 2015, the</p>		<p>1.How will you identify other residents having thepotential to be affected by the same deficient practice and what correctiveaction will be taken? All residents, staff and visitors have thepotential to be affected by the alleged deficient practice. 1.What measures will be put into place or whatsystemic changes will you make to ensure that the deficient practice does notoccur? Maintenance Director in-serviced byExecutive Director on 4/3/15 the importance of ensuring generators areinspected weekly and exercised under load for 30 minutes per month inaccordance with NFPA 99. 1.How will the corrective action be monitored toensure the deficient practice does not recur, i.e, what quality assuranceprogram will be put into place? An environmental CQI tool will beutilized weekly X 6 and monthly thereafter to monitor compliance with requiredweekly inspection and exercising under load for 30 minutes in accordance with NFPA 99. The CQI Committeereviews the audits and action plans are developed to improve performance anddetermine the need for further action. Compliance Date: May 2, 2015</p>		

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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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	<p>first and third weeks of February 2015, the first, second, and third weeks of January 2015, and the second and third weeks of December 2014. The lack of a weekly inspection of the emergency generator during the above listed weeks was verified by the maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 04/02/15 at 1:20 p.m.</p> <p>3.1-19(b)</p>				