STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	155669		07/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW TCU	395 WESTFIELD RD TCU NOBLESVILLE, IN 46060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	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). Survey Date: 07/20/15 Facility Number: 011046 Provider Number: 155669 AIM Number: NA 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 This facility is located on the fourth floor of a fully sprinklered five story building. This facility was determined to be of Type I (332) construction. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all 13 resident sleeping	K 0000	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 for 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 regulator requirements. We are requesting Paper compliance to this Life Safety Code Recertification and State Licensure Survey.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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NAME OF PROVIDER OR SUPPLIER RIVERVIEW TCU		STREET ADDRESS, CITY, STATE, ZIP CODE 395 WESTFIELD RD TCU NOBLESVILLE, IN 46060	

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	rooms. The facility has a capacity of 25 and had a census of 14 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.			
K 0032 SS=F Bldg. 01	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 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. Findings include: Based on observations with the Administrator during a tour of the facility from 11:10 a.m. to 12:20 p.m. on 07/20/15, the TCU has two emergency exits. One exit is a horizontal exit into the adjacent smoke compartment. The adjacent smoke compartment has two exit stairwells. The second exit is an exit stairwell which does not connect to an	K 0032	k-0032- It is the practice of this Unit to abide by the Life Safety Code determined appropriate for the Unit. 1. What corrective action(s) will be accomplished for those patients found to have been affected by the deficient practice; This provider completed an assessment by Fire Safety Evaluation System (FSES) to demonstrate equivalent compliance. (See Attached FSES survey). 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s)will be taken; All residents located on the 4th floor have the potential to be affected by this alleged practice. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; FSES	08/03/2015

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	exit discharge directly to the exterior. Based on interview at the time of the observations, the Administrator acknowledged each smoke compartment is not provided with at least one exit discharging directly to the exterior of the building. 3.1-19(b)		audit will be completed when structural changes are made to this Unit. 4. How the corrective actions(s) will be monitored to ensure the deficient practice will not recur; The Hospital will up date a FSES survey/audit when any life safety structural chages are made to this area. 5. What date the systemic changes will be completed; With acceptance of the FSES survey/audit, systemic corrections will be completed by 8/3/2015	
K 0034 SS=F Bldg. 01	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 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.	K 0034	K 0034 - It is the practice of this Unit to abide by the Life Safety Code determined appropriate for the Unit. 1. What corrective action(s) will be accomplished for those patients found to have been affected by the deficient practice; This provider completed an assessment by Fire Safety Evaluation System (FSES) to demonstrate equivalent compliance. (See Attached FSES survey). 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s)will be taken; All residents located on the 4th floor have the potential to be affected by this alleged practice. 3. What measures will be put into place or what systemic changes will be	08/03/2015

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	Findings include: Based on observations with the Administrator during a tour of the facility from 11:10 a.m. to 12:20 p.m. on 07/20/15, the fourth floor on which the TCU is located is divided into two smoke compartments and has three stairwell exits. Additionally, the fire resistance rating of the three exit enclosures on the first floor of the hospital to the exit discharge door is less than two hours. Based on interview at the time of the observations, the Administrator acknowledged each of the three exit discharge passageways are not separated from the remainder of the building by a two hour fire resistance rating. 3.1-19(b)		made to ensure that the deficient practice does not recur; FSES audit will be completed when structural changes are made to this Unit. 4. How the corrective actions(s) will be monitored to ensure the deficient practice will not recur; The Hospital will up date a FSES survey/audit when any life safety structural chages are made to this area. 5. What date the systemic changes will be completed; With acceptance of the FSES survey/audit, systemic corrections will be completed by 8/3/2015	