STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155785	A. BUILDING -- B. WING	06/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WEST RIVER HEALTH CAMPUS	714 S EICKHOFF RD EVANSVILLE, IN 47712

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 06/07/23 Facility Number: 012448 Provider Number: 155785 AIM Number: 201039500 At this Emergency Preparedness survey, West River Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has a capacity of 61 certified beds and had a census of 32 at the time of this visit. Quality Review completed on 06/08/23	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/07/23 Facility Number: 012448 Provider Number: 155785 AIM Number: 201039500 At this Life Safety Code survey, West River Health Campus was found not in compliance with	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Maddison Cook	ED	06/23/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 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 one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 61 and had a census of 32 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 06/08/23			
K 0131 SS=F Bldg. 01	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.			

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	Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 Based on observation and interview, the facility failed to ensure 1 of 2 single fire doors in the 2 hour fire separation wall between the Assisted Living section of the facility and the skilled health care section of the facility closed fully and latched when tested several times. LSC 8.3.3.1 states openings required to have a fire protection rating of 1 1/2 hour in a 2 hour fire wall or partition shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives. 8.3.3.2.2 states all products required shall bear an approved label. This deficient practice could affect all residents while in the dining room. Findings include: Based on observation on 06/07/23 between 12:30 p.m. and 2:30 p.m. during a tour of the facility with the Director of Plant Operations, Director of Plant Operations from a sister facility, and the Regional Facility Support person, the single 90 minute rated fire door between the kitchen and dining room, which is part of the two hour fire wall that separates the Assisted Living section and the skilled health care section of the facility did not close fully and latch when tested several times. There was a three inch gap between the door and its frame when attempted to close. Based on interview at the time of observation, the facility	K 0131	On June 20, 2023, Director of Plant Operations replaced door closer on the Kitchen Door going into the health center dining room. Door now latches on its own. Director of Plant Operations will audit x1 month for 6 months to ensure continued compliance. Results of the audit will be reviewed at the Quality Assurance Meeting at which time a decision will be made to either continue or discontinue the audit.	06/20/2023

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	Director of Plant Operations said it would not close fully due to an air flow issue. This was acknowledged by both Director's of Plant Operations and the Regional Facility Support person at the time of observation. This finding was reviewed with the Executive Director, both Director's of Plant Operations and the Regional Facility Support person during the exit conference. 3.1-19(b)			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be			

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	electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	1. Based on observation and interview, the facility failed to ensure 2 of 9 delayed egress	K 0222	The Director of Plant Operations was educated on 6/19/2023 by the	06/19/2023

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	locking arrangements were installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect at least 20 residents, as well as staff and visitors. Findings include: Based on observation on 06/07/23 between 12:30 p.m. and 2:30 p.m. during a tour of the facility with the Director of Plant Operations, Director of Plant Operations from a sister facility, and the Regional Facility Support person, the following was noted: a. The Sunporch (between the 100 and 200 halls) had a set of double exit doors was equipped with delayed egress. When the panic bar on the left side door was pushed for 15 seconds several times the door did not release from the magnetic hold located at the top of the door. However, the magnetic hold did release the door when the code was pushed on the keypad located next to the door. Based on interview at the time of observation, the facility's Director of Plant Operations acknowledged the left side exit door did not release when the panic bar was pushed for		Executive Director on NFPA K-222 EGRESS doors. The Director of Plant Operations has adjusted the mag lock on the sunporch door (between 100 and 200 halls). The Director of Plant Operations will audit the functionality of all egress doors 2x week for 3 weeks, then 1x weekly as a continuous audit. The results of these inspections will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect 32 residents in the health center. The facility census is 84.	

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	15 seconds. He did attempt to correct the issue at the time of observation, but was unsuccessful. b. The 100 hall exit door was equipped with delayed egress. When the panic bar on the door was pushed for 15 seconds several times the door did not release from the magnetic hold located at the top of the door. However, the magnetic hold did release the door when the code was pushed on the keypad located next to the door. Based on interview at the time of observation, the facility's Director of Plant Operations acknowledged the 100 hall exit door did not release when the panic bar was pushed for 15 seconds. He was able to correct the issue at the time of observation. This finding was reviewed with the Executive Director, both Director's of Plant Operations and the Regional Facility Support person during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 1 locked exit courtyard gate was readily accessible for residents, staff, and visitors. This deficient practice could affect at least 10 residents, as well as staff and visitors. Findings include: Based on observation on 06/07/23 between 12:30 p.m. and 2:30 p.m. during a tour of the facility with the Director of Plant Operations, Director of Plant Operations from a sister facility, and the Regional Facility Support person, the Courtyard exit gate was equipped with a combination magnetic lock and key lock. It could only be opened with a key, lose of power, or activation of the fire alarm system. There was no keypad located adjacent to			

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	the exit gate, additionally, there was no key located near the gate. Based on interview at the time of observation, the facility Director of Plant Operations said staff does not carry a key to the gate either. Finally, there was a key broken off in the gate handle. The facility Director of Plant Operations was able to remove the broken key at the time of observation. This finding was reviewed with the Executive Director, both Director's of Plant Operations and the Regional Facility Support person during the exit conference. 3.1-19(b)			
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to ensure 1 of 12 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all	K 0712	The Director of Plant Operations A Fire Drill on three shifts with documentation confirming the transmission of the fire alarm to the monitoring company. The Director of Plant Operations was educated by the Executive Director on NFPA 101 Fire Drills Fire drills include the transmission	06/23/2023

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	residents. Findings include: Based on record review on 06/07/23 between 9:30 a.m. and 12:30 p.m. with the Director of Plant Operations and the Regional Facility Support person present, the fire drill report dated 05/30/23 was not provided with documentation for the transmission of the alarm to the monitoring company. On the report at "Fire Alarm System Tested?" it read "N/A". Based on interview at the time of record review, the Director of Plant Operations acknowledged there was no information on the 05/30/23 fire drill report to verify that transmission of the alarm was received by the monitoring company. This finding was reviewed with the Executive Director, the facility Director of Plant Operations, Director of Plant Operations from a sister facility, and the Regional Facility Support person during the exit conference. 3.1-19(b)		of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 The Director of Plant Operations will perform fire drill 1 x per month each shift quarterly with varying times. All documentation will be uploaded and housed in TELS. Results of these Fire Drills will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect all staff, resident, and visitors of the facility.	