STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155723	A. BUILDING -- B. WING	04/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVER POINTE HEALTH CAMPUS	3001 GALAXY DR EVANSVILLE, IN 47715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/04/23 Facility Number: 002280 Provider Number: 155723 AIM Number: 201068770 At this Emergency Preparedness survey, River Pointe 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 68 certified beds. At the time of the survey, the census was 53. Quality Review completed on 04/11/23	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: 04/04/23 Facility Number: 002280 Provider Number: 155723 AIM Number: 201068770 At this Life Safety Code survey, River Pointe Health Campus was found not in compliance with	K 0000	The submission of this plan of correction does not indicate an admission by River Pointe Health Campus that the findings and allegations contained herein are accurate, true representation of the living environment provided to the residents of River Pointe Health Campus. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jordan Shots	Executive Director	04/28/2023

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 two story facility was determined to be of Type II (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 68 and had a census of 53 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 04/11/23		facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to maintain the walking surface for 1 of 7 exit discharge areas. This deficient practice could affect at least 20 residents, as well as staff and visitors. Findings include:	K 0271	1. No residents were affected by the alleged deficient practice. The Director of Plant Operations has contacted and scheduled a contractor to replace the walking surface outside the east exit. 2. All residents have the potential to be affected from the	05/10/2023

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	Based on observations on 04/04/23 between 1:00 p.m. and 3:00 p.m. during a tour of the facility with the Director of Plant Operations and Director of Plant Operations from a sister facility, the outside east exit from the 300 Unit elevator/stairwell enclosure had two, one-to-two-inch level changes in the concrete sidewalk leading to the public way. The level changes in the concrete sidewalk to the public way could be a tripping hazard while exiting from this area in the event of an emergency. Based on interview at the time of observation, the facility's Director of Plant Operations agreed there were two, one-to-two-inch level changes along the sidewalk to the public way from this exit. This finding was reviewed with the Executive Director and both Directors of Plant Operations during the exit conference. 3.1-19(b)		alleged deficient practice. The Director of Plant Operations was educated by the Executive Director on K-Tag 271: Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7. 3. As a measure on ongoing compliance, the Director of Plant Operations and/or designee will audit discharge exits 1 x per week x three months followed by 1 x per month x 3 months. 4. As a quality measure, 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.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4.			

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	Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure the corridor door to 1 of over 10 hazardous area doors, such as a carpet/supply storage room door, was provided with a self-closing device. This deficient practice could affect at least 20 residents, staff, and visitors. Findings include: Based on observations on 04/04/23 between 1:00 p.m. and 3:00 p.m. during a tour of the facility with the Director of Plant Operations and Director of Plant Operations from a sister facility, room 606 was currently being used as a storage room for carpet and carpet supplies. This room was over 50 square feet in size, and was full of carpet, carpet supplies, cardboard boxes, paper, and	K 0321	1. No residents were affected by the alleged deficient practice. The Director of Plant Operations has added a self-closing device to room 606. 2. All residents have the potential to be affected from the alleged deficient practice. The Director of Plant Operations was educated by the Executive Director on K-Tag 321: Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9.	04/04/2023

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	plastic items. The corridor door to this room was not provided with a self-closing device. Based on interview at the time of observation, the facility's Director of Plant Operations confirmed this door was not provided with a self-closing device, and further said room 606 will remain a storage room for carpet and supplies for at least another month. This finding was reviewed with the Executive Director and both Directors of Plant Operations during the exit conference. 3.1-19(b)		When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. 3. As a measure on ongoing compliance, the Director of Plant Operations and/or designee will audit self-closing doors 1 x per week x three months followed by 1 x per month x 3 months. 4. As a quality measure, 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.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72			

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	1. Based on record review and interview, the facility failed to ensure documentation for the sensitivity testing of all smoke detectors was complete. NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all residents, staff, and visitors.	K 0345	1. No residents were affected by the alleged deficient practice. The Director of Plant Operations contacted our contractor Koorsen, and sensitivity testing was completed on all smoke detectors including the 4 photo smoke detectors in the elevator shaft and 7 duct smoke detectors. Koorsen also updated paperwork to include calibrated sensitivity test instrument. Director of Plant Operations also fixed the hanging smoke detectors in rooms 301, 302, 318, and in the mechanical room by room 307. 2. All residents have the potential to be affected from the alleged deficient practice. The Director of Plant Operations was educated by the Executive Director on K-Tag 345: A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72. NFPA 72, National Fire Alarm Code, the 2010 Edition, at 14.6.2.4 requires a record of all inspections, testing, and maintenance shall be provided that includes the following information regarding tests and all the applicable information requested in	04/18/2023

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	Findings include: Based on record review on 04/04/23 between 9:30 a.m. and 1:00 p.m. with the Director of Plant Operations and Director of Plant Operations from a sister facility present, the smoke detector sensitivity test report dated 11/11/22 was not a complete report. The manufacturer's calibrated sensitivity test instrument was not included on the report. Based on interview at the time of record review, the facility's Director of Plant Operations confirmed the lack of the manufacturer's calibrated sensitivity test instrument on the 11/11/22 sensitivity testing report. This finding was reviewed with the Executive Director, and both Directors of Plant Operations during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure the documentation for the annual testing of all devices connected the fire alarm system was complete. NFPA 72, National Fire Alarm Code, the 2010 Edition, at 14.6.2.4 requires a record of all inspections, testing, and maintenance shall be provided that includes the following information regarding tests and all the applicable information requested in Figure 14.6.2.4: (1) Date (2) Test frequency (3) Name of property (4) Address (5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number		Figure 14.6.2.4: o Date o Test frequency o Name of property o Address o Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number o Name, address, and representative of approving agency (ies) o Designation of the detector(s) tested o Functional test of detectors o *Functional test of required sequence of operations o Check of all smoke detectors o Loop resistance for all fixed-temperature, line-type heat detectors o Functional test of mass notification system control units o Functional test of signal transmission to mass notification systems o Functional test of ability of mass notification system to silence fire alarm notification appliances o Tests of intelligibility of mass notification system speakers o Other tests as required by the equipment manufacturer's published instructions o Other tests as required by the authority having jurisdiction o Signatures of tester and approved authority representative	

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	(6) Name, address, and representative of approving agency (ies) (7) Designation of the detector(s) tested (8) Functional test of detectors (9) *Functional test of required sequence of operations (10) Check of all smoke detectors (11) Loop resistance for all fixed-temperature, line-type heat detectors (12) Functional test of mass notification system control units (13) Functional test of signal transmission to mass notification systems (14) Functional test of ability of mass notification system to silence fire alarm notification appliances (15) Tests of intelligibility of mass notification system speakers (16) Other tests as required by the equipment manufacturer's published instructions (17) Other tests as required by the authority having jurisdiction (18) Signatures of tester and approved authority representative (19) Disposition of problems identified during test (e.g., system owner notified, problem corrected/successfully retested, device abandoned in place). NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances		o Disposition of problems identified during test (e.g., system owner notified, problem corrected/successfully retested, device abandoned in place). NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: o Control unit trouble signals o Remote annunciators o Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) o Notification appliances o Magnetic hold-open devices 3. As a measure on ongoing compliance, the Director of Plant Operations and/or designee will audit the smoke detectors in the building 1 x per week x three months followed by 1 x per month x 3 months. 4. As a quality measure, 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.	

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	155723	A. BUILDING 01 B. WING	04/04/2023

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	e. Magnetic hold-open devices This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 04/04/23 between 9:30 a.m. and 1:00 p.m. with the Director of Plant Operations and Director of Plant Operations from a sister facility present, the most recent annual fire alarm system inspection/testing report dated 11/11/22 indicated seven duct smoke detectors and four photo smoke detectors (in elevator shafts and elevator pits) were "Not Tested". The report gave no reason for the "Not Tested" comments. Based on interview at the time of record review, the facility's Director of Plant Operations said he was not sure why the duct smoke detectors and photo smoke detectors were not tested during the most recent annual fire alarm system inspection/test. This finding was reviewed with the Executive Director, and both Directors of Plant Operations during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators			

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	c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect at least 20 residents, as well as staff, and visitors. Findings include: Based on observations on 04/04/23 between 1:00 p.m. and 3:00 p.m. during a tour of the facility with the Director of Plant Operations and Director of Plant Operations from a sister facility, the following was noted: a. The ceiling mounted smoke detector in the corridor outside rooms 301 and 302 was hanging from its wires about two inches from the ceiling. b. The ceiling mounted smoke detector in resident room 318 was hanging from its wires about one inch from the ceiling. c. The ceiling mounted smoke detector in the Mechanical Room near room 307 was hanging from its wires about one inch from the ceiling. Based on interview at the time of each observation, the facility's Director of Plant Operations acknowledged the previously mentioned smoke detectors not being flush with the ceiling and said he would correct them as soon as possible. Note: The facility's Director of Plant Operations did correct the issues with the corridor smoke detector and the smoke detector in room 318 before the end of the survey. This finding was reviewed with the Executive Director and both Directors of Plant Operations during the exit conference.			

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K 0353 SS=E Bldg. 01	3.1-19(b) NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure the ceiling in 1 of 5 sprinklered smoke compartments was maintained to allow sprinkler heads to function to their full capability. This deficient practice could affect at least 20 residents, staff, and visitors. Findings include: Based on observations on 04/04/23 between 1:00 p.m. and 3:00 p.m. during a tour of the facility with the Director of Plant Operations and Director of Plant Operations from a sister facility, the sprinkler head in the corridor outside room 316 was missing the escutcheon ring which left a one half inch gap around the sprinkler pipe to the interstitial space between the first and second floors. Based on	K 0353	1. No residents were affected by the alleged deficient practice. The Director of Plant Operations has added an escutcheon plate to the sprinkler head outside room 316. 2. All residents have the potential to be affected from the alleged deficient practice. The Director of Plant Operations was educated by the Executive Director on K-Tag 353: Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and	04/07/2023

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	155723	A. BUILDING 01 B. WING	04/04/2023

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	interview at the time of observation, the facility's Director of Plant Operations acknowledged the escutcheon ring was missing and said he would have it replaced as soon as possible. This finding was reviewed with the Executive Director and both Director's of Plant Operations during the exit conference. 3.1-19(b)		Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection, and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source 9.7.5, 9.7.7, 9.7.8, and NFPA 25 3. As a measure on ongoing compliance, the Director of Plant Operations and/or designee will audit sprinkler heads 1 x per week x three months followed by 1 x per month x 3 months. 4. As a quality measure, 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.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching			

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	155723	A. BUILDING 01 B. WING	04/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVER POINTE HEALTH CAMPUS	3001 GALAXY DR EVANSVILLE, IN 47715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of over 100 corridor doors would resist the passage of smoke. This deficient practice could affect at least 20 residents, as well as staff and visitors. Findings include: Based on observations on 04/04/23 between 1:00 p.m. and 3:00 p.m. during a tour of the facility with the Director of Plant Operations and Director of	K 0363	1. No residents were affected by the alleged deficient practice. The Director of Plant Operations has repaired the two holes in the door. 2. All residents have the potential to be affected from the alleged deficient practice. The Director of Plant Operations was educated by the Executive Director on K-Tag 363: Doors	04/04/2023

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	155723	A. BUILDING 01 B. WING	04/04/2023

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RIVER POINTE HEALTH CAMPUS	3001 GALAXY DR EVANSVILLE, IN 47715

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	Plant Operations from a sister facility, the corridor door to the 300 Unit Clean Utility Room had two, one fourth inch holes through the door just above the keypad/door handle. Based on interview at the time of observation the facility's Director of Plant Operations agreed the door was not smoke resistant and the holes need to be repaired. This finding was reviewed with the Executive Director and both Director's of Plant Operations during the exit conference. 3.1-19(b)		protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbs. is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In	

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	155723	A. BUILDING 01 B. WING	04/04/2023

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RIVER POINTE HEALTH CAMPUS	3001 GALAXY DR EVANSVILLE, IN 47715

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			sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 3. As a measure on ongoing compliance, the Director of Plant Operations and/or designee will conduct a one-time audit to ensure that all corridor doors resist the passage of smoke. DPO to ensure that when we replace door handles, we also repair any holes in the door. 4. As a quality measure, 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.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control			

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	155723	A. BUILDING 01 B. WING	04/04/2023

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RIVER POINTE HEALTH CAMPUS	3001 GALAXY DR EVANSVILLE, IN 47715

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	system in REMARKS. Based on observation and interview, the facility failed to ensure 1 of 5 smoke barrier walls was protected to maintain the smoke resistance of the smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect at least 20 residents, as well as staff and visitors. Findings include: Based on observations on 04/04/23 between 1:00 p.m. and 3:00 p.m. during a tour of the facility with the Director of Plant Operations and Director of Plant Operations from a sister facility, the smoke barrier wall above the smoke barrier doors near room 311 had a two inch hold penetrating the wall with two wires running through it that was not properly fire stopped. Based on interview at the time of observation, the facility's Director of Plant Operations said the opening through the smoke barrier wall would be filled with a proper fire stop material as soon as possible. This finding was reviewed with the Executive Director and both Director's of Plant Operations during the exit conference. 3.1-19(b)	K 0372	1. No residents were affected by the alleged deficient practice. The Director of Plant Operations has properly sealed the smoke barrier walls where the cables were ran. 2. All residents have the potential to be affected from the alleged deficient practice. The Director of Plant Operations was educated by the Executive Director on K-Tag 372: Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) 3. As a measure on ongoing compliance, the Director of Plant Operations and/or designee will complete one-time audits of all Fire separations in the attic. 4. As a quality measure, 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.	04/04/2023
K 0374 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke			

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	155723	A. BUILDING 01 B. WING	04/04/2023

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RIVER POINTE HEALTH CAMPUS	3001 GALAXY DR EVANSVILLE, IN 47715

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Bldg. 01	Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 5 sets of smoke barrier doors would close and latch to form a smoke resistant barrier. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 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 at least 20 residents, as well as staff and visitors. Findings include: Based on observations on 04/04/23 between 1:00 p.m. and 3:00 p.m. during a tour of the facility with the Director of Plant Operations and Director of Plant Operations from a sister facility, the set of 90 minute rated smoke barrier/fire barrier doors between the 300 Unit and the adjacent elevator/stairwell enclosure did not close completely and latch when tested several times. These doors were equipped with latching	K 0374	1. No residents were affected by the alleged deficient practice. The Director of Plant Operations has repaired the latch on the affected door to ensure a smoke resistant barrier. 2. All residents have the potential to be affected from the alleged deficient practice. The Director of Plant Operations was educated by the Executive Director on K-Tag 374: Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic closing, do not require latching, and are not required to swing in the direction of egress	04/06/2023

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	hardware. This was acknowledged by the facility's Director of Plant Operations at the time of observation, who further said he would fix the latching mechanism as soon as possible. This finding was reviewed with the Executive Director and both Director's of Plant Operations during the exit conference. 3.1-19(b)		travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 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. 3. As a measure on ongoing compliance, the Director of Plant Operations and/or designee will audit smoke barrier doors to verify they latch properly 1 x per week x three months followed by 1 x per month x 3 months. 4. As a quality measure, 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.	