PRINTED: 05/10/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155723	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  04/04/2023	
	PROVIDER OR SUPPLIER		3001 G	ADDRESS, CITY, STATE, ZIP COD ALAXY DR SVILLE, IN 47715		_
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
E 0000						_
Bldg		paredness Survey was ndiana Department of Health in CFR 483.73.	E 0000			
	Pointe Health Camp with Emergency Pr Medicare and Medi and Suppliers, 42 C The facility has 68 the survey, the cens	002280 155723 068770  Preparedness survey, River pus was found in compliance eparedness Requirements for icaid Participating Providers CFR 483.73.  certified beds. At the time of				
K 0000						
Bldg. 01	Licensure Survey w	002280 155723	K 0000	The submission of this plan of correction does not indicate ar admission by River Pointe Heat Campus that the findings and allegations contained herein at accurate, true representation of the living environment provided the residents of River Pointe Health Campus. The facility hereby maintains it is in substantial compliance with all	n alth re of d to	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Health Campus was found not in compliance with

At this Life Safety Code survey, River Pointe

(X6) DATE

state and federal requirements

TITLE

governing the management of this

04/28/2023 Jordan Shots **Executive Director** 

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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155723		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/04/2023	
	PROVIDER OR SUPPLIE		3001 G	ADDRESS, CITY, STATE, ZIP COD GALAXY DR SVILLE, IN 47715	
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	Requirements for I Medicare/Medicaid Life Safety from F National Fire Prote Life Safety Code ( Health Care Occup This two story faci Type II (111) cons sprinklered. The fi with hard wired sn spaces open to the sleeping rooms. T and had a census o  All areas where the access were sprink facility services we Quality Review co	d, 42 CFR Subpart 483.90(a), ire and the 2012 edition of the ection Association (NFPA) 101, LSC), Chapter 19, Existing pancies and 410 IAC 16.2.  Ity was determined to be of truction and was fully acility has a fire alarm system noke detectors in the corridors, corridors, and all resident the facility has a capacity of 68 of 53 at the time of this survey.	TAG	facility. It is thus submitted as matter of statute only. The fa respectfully requests from the department a desk review for substantial compliance.	cility
K 0271 SS=E Bldg. 01	7.7, provides a lethe provisions of changes in elevative of obstruction discharge shall be travel surface.  18.2.7, 19.2.7  Based on observative failed to maintain discharge areas.		K 0271	1. No residents were affect by the alleged deficient praction. The Director of Plant Operation has contacted and scheduled contractor to replace the walk surface outside the east exit.  2. All residents have the potential to be affected from the surface of the surface of the surface.	ce. ons a ing

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155723		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY  COMPLETED  04/04/2023	
	PROVIDER OR SUPPLIER		3001 G	ADDRESS, CITY, STATE, ZIP COD BALAXY DR SVILLE, IN 47715	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	p.m. and 3:00 p.m. the Director of Plant Plant Operations from the 30 enclosure had two, in the concrete side. The level changes in public way could be from this area in the Based on interview facility's Director of were two, one-to-two the sidewalk to the This finding was reducing the exit confidence of the sidewalk to the 3.1-19(b)	ons on 04/04/23 between 1:00 during a tour of the facility with to Operations and Director of om a sister facility, the outside 00 Unit elevator/stairwell one-to-two-inch level changes walk leading to the public way. In the concrete sidewalk to the eat tripping hazard while exiting event of an emergency. The time of observation, the fall Plant Operations agreed there wo-inch level changes along public way from this exit.		alleged deficient practice. The Director of Plant Operations educated by the Executive Director on K-Tag 271: Exit discharge is arranged in accordance with 7.7, provide level walking surface meeting provisions of 7.1.7 with respectanges in elevation and shamaintained free of obstruction Additionally, the exit discharge shall be a hard packed all-west travel surface. 18.2.7, 19.2.7 3. As a measure on ongo compliance, the Director of F. Operations and/or designee audit discharge exits 1 x per x three months followed by 1 month x 3 months.  4. As a quality measure, the results of these inspections we presented by Executive Director the QAPI committee for furth recommendations and continuitil the Quality Assurance T determines substantial compliance has been achiever.	s a g the ect to all be ns. ge eather ing Plant will week x per ne vill be ctor to er nue ream
K 0321 SS=E Bldg. 01	barrier having 1-he (with 3/4 hour fire automatic fire exti- accordance with 8 approved automat option is used, the from other spaces				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED			ETED	
		155723	B. W	NG		04/04/	/2023
				CTD FFT A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	2					
חו/בם ם		MDUE			ALAXY DR		
RIVERP	OINTE HEALTH CA	AMPUS		EVAINS	VILLE, IN 47715		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	IENCIE ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Doors shall be sel	f-closing or					
	automatic-closing	and permitted to have					
	nonrated or field-a	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)						
	-	nance, and Paint Shops					
		ooms (exceeding 64					
	gallons)						
	e. Trash Collection						
	(exceeding 64 gal	•					
		orage Rooms/Spaces					
	(over 50 square fe	•					
	-	classified as Severe					
	Hazard - see K32				<u>.</u> .		
		on and interview, the facility	K 0	321	No residents were affect		04/04/2023
		corridor door to 1 of over 10			by the alleged deficient practic		
		rs, such as a carpet/supply			The Director of Plant Operatio		
		was provided with a			has added a self-closing device	e to	
	_	This deficient practice could			room 606.		
	affect at least 20 res	sidents, staff, and visitors.			2. All residents have the		
	E' 1' ' 1 1				potential to be affected from the		
	Findings include:				alleged deficient practice. The		
	D	ons on 04/04/23 between 1:00			Director of Plant Operations w	as	
		during a tour of the facility with			educated by the Executive	douc	
					Director on K-Tag 321: Hazard	Jous	
	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				areas are protected by a fire		
					barrier having 1-hour fire	r fire	
					resistance rating (with 3/4-hou		
					rated doors) or an automatic fi	ie	
	_	ze, and was full of carpet,			extinguishing system in	E 0	
	carpet supplies, care	dboard boxes, paper, and	1		accordance with 8.7.1 or 19.3.	5.9.	

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f ´		(X2) MUL	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING	01	COMPL	ETED	
		155723	B. WING	B. WING			04/04/2023	
			<u> </u>	STREET A	DDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER				ALAXY DR			
RIVER P	OINTE HEALTH CA	AMPUS			VILLE, IN 47715			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PR	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	*	corridor door to this room was			When the approved automatic			
		self-closing device. Based on			extinguishing system option is			
		e of observation, the facility's			used, the areas shall be separ	ated		
	-	perations confirmed this door			from other spaces by smoke			
	-	ith a self-closing device, and			resisting partitions and doors i			
	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				accordance with 8.4. Doors sh	all		
					be self-closing or			
					automatic-closing and permitte	ed to		
					have nonrated or field-applied			
		-			protective plates that do not	4		
	during the exit conf	erence.			exceed 48 inches from the bot	lom		
	3.1-19(b)				of the door.  3. As a measure on ongoin	a		
	3.1-19(0)				<ol><li>As a measure on ongoin compliance, the Director of Pla</li></ol>	-		
					Operations and/or designee w			
					audit self-closing doors 1 x per			
					week x three months followed			
					x per month x 3 months.	Dy 1		
					4. As a quality measure, the	<b>.</b>		
					results of these inspections wi			
					presented by Executive Direct			
					the QAPI committee for further			
					recommendations and continu			
					until the Quality Assurance Te			
					determines substantial			
					compliance has been achieved	d.		
				İ	•			
K 0345	NFPA 101							
SS=F	Fire Alarm System	n - Testing and						
Bldg. 01	Maintenance							
	Fire Alarm System	n - Testing and						
	Maintenance							
	•	n is tested and maintained						
		n an approved program						
		e requirements of NFPA 70,						
		Code, and NFPA 72,						
		m and Signaling Code.						
		n acceptance, maintenance						
	and testing are rea							
	9.6.1.3, 9.6.1.5, N	FPA 70, NFPA 72	l					

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	PROVIDER OR SUPPLIER		3001	T ADDRESS, CITY, STATE, ZIP COD GALAXY DR ISVILLE, IN 47715		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	Based on record facility failed to ens	review and interview, the ure documentation for the	K 0345	No residents were affect by the alleged deficient pract.  The Director of Plant Operation  The	oted 04/18/2023 ice.	
	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			The Director of Plant Operatic contacted our contractor Koo and sensitivity testing was	rsen,	
				completed on all smoke dete including the 4 photo smoke detectors in the elevator shafe		
	remained within its	cate that the detector has listed and marked sensitivity time between calibration tests		7 duct smoke detectors. Kool also updated paperwork to in calibrated sensitivity test		
	shall be permitted to 5 years. If the frequency	be extended to a maximum of nency is extended, records of		instrument. Director of Plant Operations also fixed the har		
	trends of these alarr	sance alarms and subsequent ns shall be maintained. In e nuisance alarms show an		smoke detectors in rooms 30 302, 318, and in the mechani room by room 307.		
	shall be performed.	evious year, calibration tests  To ensure that each smoke s listed and marked sensitivity		<ol> <li>All residents have the potential to be affected from alleged deficient practice. The</li> </ol>		
	range, it shall be tes (1) Calibrated test n	ted using any of the methods:		Director of Plant Operations velocated by the Executive	was	
	instrument.	calibrated sensitivity test quipment arranged for the		Director on K-Tag 345: A fire system is tested and maintain in accordance with an approx	ned	
	` '	fire alarm control unit by the detector causes a signal		program complying with the requirements of NFPA 70, National Electric Code, and N	IEDA	
	at the control unit w its listed sensitivity	where its sensitivity is outside range.		72, National Fire Alarm and Signaling Code. Records of	NFFA	
	to the authority hav	sensitivity method acceptable ing jurisdiction. have sensitivity outside the		system acceptance, maintenary and testing are readily availa 9.6.1.3, 9.6.1.5, NFPA 70, NI	ble.	
	listed and marked so cleaned and recalib	ensitivity range shall be rated or replaced.		72. NFPA 72, National Fire A Code, the 2010 Edition, at	larm	
	measured using any an unmeasured con-	vity cannot be tested or spray device that administers centration of aerosol into the		14.6.2.4 requires a record of inspections, testing, and maintenance shall be provide		
	detector. This defice residents, staff, and	visitors.		includes the following informate regarding tests and all the applicable information reques		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>		COMPLETED	
		155723	B. W	ING		04/04	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	₹			ALAXY DR		
	OINTE HEALTH CA	AMDUS			VILLE, IN 47715		
RIVERP	OINTE REALTH CA	AIVIF US		EVAINS	VILLE, IN 4// 10		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX (EACH COR)		(EACH CORRECTIVE ACTION SHOULD BE COM CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Findings include:				Figure 14.6.2.4:		
					o Date		
		view on 04/04/23 between 9:30			o Test frequency		
	-	with the Director of Plant			o Name of property		
	-	ector of Plant Operations from			o Address		
		ent, the smoke detector			o Name of person performing		
		rt dated 11/11/22 was not a			inspection, maintenance, tests		
	complete report. The manufacturer's calibrated				combination thereof, and affilia	ation,	
	sensitivity test instrument was not included on				business address, and telepho	one	
	the report. Based on interview at the time of				number		
	record review, the facility's Director of Plant				o Name, address, and		
	Operations confirmed the lack of the				representative of approving ag	gency	
		orated sensitivity test			(ies)		
	instrument on the 1	1/11/22 sensitivity testing			o Designation of the detector	r(s)	
	report.				tested		
					o Functional test of detectors		
		viewed with the Executive			o *Functional test of required		
		Directors of Plant Operations			sequence of operations		
	during the exit conf	erence.			o Check of all smoke detecto	ors	
					o Loop resistance for all		
	3.1-19(b)				fixed-temperature, line-type he	eat	
					detectors		
		review and interview, the			o Functional test of mass		
	•	sure the documentation for the			notification system control unit	ts	
		devices connected the fire			o Functional test of signal		
	•	omplete. NFPA 72, National			transmission to mass notificati	on	
		ne 2010 Edition, at 14.6.2.4			systems		
		all inspections, testing, and			o Functional test of ability of		
		be provided that includes the			mass notification system to		
	-	on regarding tests and all the			silence fire alarm notification		
		ion requested in Figure			appliances		
	14.6.2.4:				o Tests of intelligibility of mas	SS	
	(1) Date				notification system speakers	tla a	
	(2) Test frequency	4			o Other tests as required by	ıne	
	(3) Name of proper	ıy			equipment manufacturer's		
	(4) Address				published instructions	u	
		performing inspection,			o Other tests as required by	ıne	
		or combination thereof, and			authority having jurisdiction		
		address, and telephone			o Signatures of tester and		
1	number		1		approved authority representa	tive	I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155723		A. Bl	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/04/2023		
	POINTE HEALTH CA		•	3001 G	ADDRESS, CITY, STATE, ZIP COD ALAXY DR VILLE, IN 47715		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION
TAG	` `	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	(6) Name, address, approving agency (	and representative of			o Disposition of problems	tom	
		the detector(s) tested			identified during test (e.g., sys owner notified, problem	tem	
	(8) Functional test of detectors				corrected/successfully retested	d,	
	(9) *Functional test of required sequence of				device abandoned in place).		
	operations				NFPA 72, Section 14.3.1 state		
	(10) Check of all smoke detectors				that unless otherwise permitte	-	
	(11) Loop resistance for all fixed-temperature, line-type heat detectors				14.3.2, visual inspections shall		
	(12) Functional test of mass notification system				performed in accordance with schedules in Table 14.3.1, or		
	control units				often if required by the authori		
	(13) Functional test of signal transmission to mass				having jurisdiction. Table 14.3	-	
	notification systems				states that the following must		
	(14) Functional test of ability of mass notification				visually inspected semi-annua		
	system to silence fire alarm notification appliances				o Control unit trouble signals	-	
	(15) Tests of intelligibility of mass notification				o Remote annunciators		
	system speakers				o Initiating devices (e.g. duct		
		required by the equipment			detectors, manual fire alarm		
	manufacturer's pub				boxes, heat detectors, smoke		
		required by the authority			detectors, etc.)		
	having jurisdiction	ester and approved authority			o Notification appliances	_	
	representative	ester and approved authority			<ul><li>o Magnetic hold-open device</li><li>3. As a measure on ongoin</li></ul>		
	*	problems identified during test			compliance, the Director of Pla	-	
	(e.g., system owner				Operations and/or designee w		
	corrected/successfu				audit the smoke detectors in the		
	abandoned in place				building 1 x per week x three		
	_	14.3.1 states that unless			months followed by 1 x per mo	onth	
	otherwise permitted	d by 14.3.2, visual inspections			x 3 months.		
	-	in accordance with the			4. As a quality measure, the	9	
		14.3.1, or more often if required			results of these inspections wi		
		ving jurisdiction. Table 14.3.1			presented by Executive Direct		
		wing must be visually			the QAPI committee for furthe		
	inspected semi-ann	-			recommendations and continu		
	a. Control unit troub. Remote annuncia	_			until the Quality Assurance Te	am	
					determines substantial	4	
		s (e.g. duct detectors, manual eat detectors, smoke detectors,			compliance has been achieve	a.	
	etc.)	eat detectors, smoke detectors,					
	d. Notification appl	iances					
	т жүрү.		1		l		

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	PROVIDER OR SUPPLIEF		3001 G	ADDRESS, CITY, STATE, ZIP COD SALAXY DR SVILLE, IN 47715		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	e. Magnetic hold-op This deficient pract in the facility.	pen devices ice could affect all occupants				
	Findings include:					
	a.m. and 1:00 p.m. Operations and Dira sister facility pres alarm system inspect 11/11/22 indicated and four photo smooth shafts and elevator report gave no reason comments. Based or record review, the formula of the smoke detectors and sister of the smoke detectors and present the sister of the	with the Director of Plant ector of Plant Operations from ent, the most recent annual fire ction/testing report dated seven duct smoke detectors ke detectors (in elevator pits) were "Not Tested". The on for the "Not Tested" on interview at the time of facility's Director of Plant was not sure why the duct d photo smoke detectors were e most recent annual fire alarm est.				
	_	viewed with the Executive Directors of Plant Operations ference.				
	3.1-19(b)					
	facility failed to ma in accordance with 101 Sections 19.3.4 14.3.1 states that ur 14.3.2, visual inspe accordance with the more often if requir jurisdiction. Table	_				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155723	B. W	ING		04/04/	2023
	PROVIDER OR SUPPLIES			3001 G	ADDRESS, CITY, STATE, ZIP COD ALAXY DR		
RIVER P	OINTE HEALTH CA	AMPUS		EVANS	VILLE, IN 47715		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	s (e.g. duct detectors, manual eat detectors, smoke detectors,					
	etc.)	eat detectors, smoke detectors,					
	d. Notification appl	iances					
	e. Magnetic hold-open devices						
		ice could affect at least 20					
	residents, as well as						
	Findings include:						
	Based on observation	ons on 04/04/23 between 1:00					
		during a tour of the facility with					
	1	nt Operations and Director of					
	Plant Operations from a sister facility, the						
	following was noted						
	_	nted smoke detector in the					
		oms 301 and 302 was hanging					
		t two inches from the ceiling.					
		inted smoke detector in resident					
	inch from the ceilin	ring from its wires about one					
		nted smoke detector in the					
	_	near room 307 was hanging					
		t one inch from the ceiling.					
	Based on interview	_					
	observation, the fac	cility's Director of Plant					
		ledged the previously					
		letectors not being flush with					
		he would correct them as					
	soon as possible.						
	Note: The facility's	s Director of Plant Operations					
		es with the corridor smoke					
		oke detector in room 318					
	before the end of th						
		viewed with the Executive					
		Directors of Plant Operations					
	during the exit conf	erence.					
	I		- 1				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  01			(X3) DATE SURVEY COMPLETED		
		155723	B. WING			04/04/	2023
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  3001 GALAXY DR  EVANSVILLE, IN 47715				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	REGULATORY OR  3.1-19(b)  NFPA 101  Sprinkler System - Sprinkler System - Automatic sprinkle are inspected, tes accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location an a) Date sprinkler  b) Who provided  c) Water system  Provide in REMAF coverage for any r automatic sprinkle 9.7.5, 9.7.7, 9.7.8, Based on observation failed to ensure the smoke compartmen sprinkler heads to for This deficient practic residents, staff, and  Findings include:	- Maintenance and Testing - And Standpipe systems - Ited, and maintained in - MIFPA 25, Standard for the - Iteg, and Maintaining of - Protection Systems Iteg are maintained in a readily available Iteg are maintained in a readily source - Item and readily available Item are readily a		G	1. No residents were affect by the alleged deficient practic has added an escutcheon plat the sprinkler head outside roor 316.  2. All residents have the potential to be affected from thalleged deficient practice. The Director of Plant Operation has added an escutcheon plat the sprinkler head outside roor 316.	ed ee. ns e to m	
	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				Director of Plant Operations w educated by the Executive Director on K-Tag 353: Automosprinkler and standpipe system are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and	atic ns	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155723	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE COMPI 04/04	LETED		
	PROVIDER OR SUPPLIER		3001 0	ADDRESS, CITY, STATE, ZIP CO GALAXY DR SVILLE, IN 47715	OD			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	RECTION IOULD BE PPROPRIATE	LD BE COMPLETION DATE		
	Director of Plant Operation of P	viewed with the Executive virector's of Plant Operations		Maintaining of Water-bar Protection Systems. Results of these inspection, and testing maintained in a secure and readily available.  a) Date sprinkler systemethecked b) Who provided systemechecked b) Water system supply 9.7.5, 9.7.7, 9.7.8, and 3. As a measure on compliance, the Director Operations and/or designated sprinkler heads 1 x three months followed month x 3 months. 4. As a quality meass results of these inspect presented by Executive the QAPI committee for recommendations and until the Quality Assurated determines substantial compliance has been as	ecords of nance, are location m last m test y source NFPA 25 ongoing or of Plant gnee will x per week d by 1 x per ure, the tions will be e Director to r further continue ance Team			
K 0363 SS=E Bldg. 01	than required enclexits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containir	corridor openings in other osures of vertical openings, is areas resist the passage made of 1 3/4 inch wood or other material in its grire for at least 20 fully sprinklered smoke only required to resist the corridor doors and doors in its grire for at least 20 fully sprinklered smoke only required to resist the corridor doors and doors in its factorial in the factorial in the corridor opening flammable or its factorial in the corridor opening in other openings, in						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155723		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       01       COMPLETED         B. WING       04/04/2023					
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 3001 GALAXY DR EVANSVILLE, IN 47715				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	CMS regulation. Tapply to auxiliary signammable or come Clearance between covering is not existed as the door closed with a complex of the doo	en bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping hen a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are ed protective plates of re permitted. Dutch doors are permitted. Dutch doors are permitted. Door beled and made of steel or compliance with 8.3, compartment is fire window assemblies are a sprinklered compartments ctions in area or fire a or frames in window  Parts 403, 418, 460, 482,  S details of doors such as angs, automatics closing  on and interview, the facility of over 100 corridor doors would fire smoke. This deficient taleast 20 residents, as well	K 0363	<ol> <li>No residents were affect by the alleged deficient practic The Director of Plant Operation has repaired the two holes in todoor.</li> <li>All residents have the potential to be affected from the alleged deficient practice. The Director of Plant Operations we ducated by the Executive Director on K-Tag 363: Doors</li> </ol>	ce. ons the		

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155723	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 04/04/2023				
NAME OF PROVIDER OR SUPPLIER RIVER POINTE HEALTH CAMPUS			3001 (	STREET ADDRESS, CITY, STATE, ZIP COD 3001 GALAXY DR EVANSVILLE, IN 47715					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N (X5) BE COMPLETION DATE				
	door to the 300 Unione fourth inch hole the keypad/door hat the time of observar Plant Operations agresistant and the ho	om a sister facility, the corridor to Clean Utility Room had two, less through the door just above andle. Based on interview at the tion the facility's Director of greed the door was not smoke less need to be repaired.  Viewed with the Executive Director's of Plant Operations Ference.		protecting corridor openings other than required enclosure vertical openings, exits, or hazardous areas resist the passage of smoke and are of 1 3/4 inch solid-bonded wood or other material capa resisting fire for at least 20 minutes. Doors in fully spring smoke compartments are or required to resist the passa smoke. Corridor doors and to rooms containing flamma combustible materials have positive latching hardware. latches are prohibited by CI regulation. These requirement apply to auxiliary space do not contain flammable or combustible material. Clear between bottom of door and covering is not exceeding 1. Powered doors complying with a device capable of kethe door closed when a force lbs. is applied. There is not impediment to the closing of doors. Hold open devices the release when the door is pure or pulled are permitted. Nor protective plates of unlimited height are permitted. Dutch meeting 19.3.6.3.6 are permore to the material serior of the ma	made core able of aklered nly ge of doors able or  Roller MS ents do s that r ance d floor inch. with ovided eping se of 5 f the nat ashed d doors nitted. d and drials in the				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155723		A. BUILDING 01  B. WING		COMPLETED 04/04/2023					
NAME OF PROVIDER OR SUPPLIER RIVER POINTE HEALTH CAMPUS			3001 G	STREET ADDRESS, CITY, STATE, ZIP COD  3001 GALAXY DR  EVANSVILLE, IN 47715					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE				
				sprinklered compartments the are no restrictions in area or fi resistance of glass or frames window assemblies. 19.3.6.3, CFR Parts 403, 418, 460, 482 483, and 485  3. As a measure on ongoir compliance, the Director of PI Operations and/or designee we conduct a one-time audit to ensure that all corridor doors resist the passage of smoke. It to ensure that when we replace door handles, we also repair a holes in the door.  4. As a quality measure, the results of these inspections we presented by Executive Direct the QAPI committee for further recommendations and continuuntil the Quality Assurance Tedetermines substantial compliance has been achieve	re in 42 de d				
K 0372 SS=E Bldg. 01	Barrie Subdivision of Buil Barrier Construction 2012 EXISTING Smoke barriers shall be posteriored shall be posteriored at the subdivided for smooth of the smoke barriers.  19.3.7.3, 8.6.7.1(1)	all be constructed to a ance rating per 8.5. Smoke ermitted to terminate at an e dampers are not required as in fully ducted HVAC approved sprinkler system oke compartments adjacent er.							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155723		A. BUI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/04/2023			
NAME OF PROVIDER OR SUPPLIER RIVER POINTE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP COD 3001 GALAXY DR EVANSVILLE, IN 47715				
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION		P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
V 0274	failed to ensure 1 of protected to maintai smoke barrier. LSC smoke barriers to be with LSC Section 8 hour fire resistive ra could affect at least and visitors.  Findings include:  Based on observation p.m. and 3:00 p.m. the Director of Plan Plant Operations fro barrier wall above to room 311 had a two with two wires runn properly fire stoppe time of observation. Operations said the barrier wall would be material as soon as This finding was red Director and both D during the exit confidence.	on and interview, the facility of 5 smoke barrier walls was in the smoke resistance of the of Section 19.3.7.5 requires the constructed in accordance of and shall have a minimum 1/2 tating. This deficient practice 20 residents, as well as staff  ons on 04/04/23 between 1:00 during a tour of the facility with to Operations and Director of om a sister facility, the smoke the smoke barrier doors near of inch hold penetrating the wall along through it that was not d. Based on interview at the the facility's Director of Plant opening through the smoke of filled with a proper fire stop possible.  viewed with the Executive birector's of Plant Operations	K 03	72	1. No residents were affect by the alleged deficient practic. The Director of Plant Operation has properly sealed the smok 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 we educated by the Executive Director on K-Tag 372: Smok barriers shall be constructed the 1/2-hour fire resistance rating 8.5. Smoke barriers shall be permitted to terminate at an awall. Smoke dampers are not required in duct penetrations fully ducted HVAC systems wan approved sprinkler system installed for smoke compartment adjacent to the smoke barrier 19.3.7.3, 8.6.7.1(1)  3. As a measure on ongoin compliance, the Director of Ploperations and/or designee we complete one-time audits of a Fire separations in the attic.  4. As a quality measure, the results of these inspections we presented by Executive Director the QAPI committee for further recommendations and continuantil the Quality Assurance Tedetermines substantial compliance has been achieved.	ce. ce. cons	04/04/2023	
K 0374 SS=E	NFPA 101 Subdivision of Bui	lding Spaces - Smoke						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155723	f /	MULTIPLE CONSTRUCTION BUILDING <u>01</u> WING		(X3) DATE SURVEY COMPLETED 04/04/2023	
NAME OF PROVIDER OR SUPPLIER RIVER POINTE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP COD  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
Bldg. 01	Barrier Doors 2012 EXISTING Doors in smoke basolid bonded wood construction that r Nonrated protectivare permitted. Doo fixed fire window as are self-closing or require latching, a in the direction of provides a minimum for swinging or ho 19.3.7.6, 19.3.7.8, Based on observation failed to ensure 1 of would close and late barrier. LSC, Section barriers to close the minimum clearance which is defined as movement of smoke affect at least 20 res visitors.  Findings include:  Based on observation p.m. and 3:00 p.m. of the Director of Plan Plant Operations from minute rated smoke between the 300 Un elevator/stairwell er completely and late	re plates of unlimited height ors are permitted to have assemblies per 8.5. Doors automatic-closing, do not and are not required to swing regress travel. Door opening of unclear width of 32 inches rizontal doors.  19.3.7.9  In and interview, the facility of sets of smoke barrier doors that doors and interview, the facility of sets of smoke barrier doors that doors had comply with LSC, Section 19.3.7.8 requires that doors had comply with LSC, Section 18.5.4.1 requires doors in smoke opening leaving only the necessary for proper operation 1/8 inch to restrict the facility. This deficient practice could idents, as well as staff and one on 04/04/23 between 1:00 during a tour of the facility with the Operations and Director of one a sister facility, the set of 90 barrier/fire barrier doors	K 0.	374	1. No residents were affect by the alleged deficient practic. The Director of Plant Operation has repaired the latch on the affected door to ensure a smooresistant barrier.  2. All residents have the potential to be affected from the alleged deficient practice. The Director of Plant Operations we educated by the Executive Director on K-Tag 374: Doors 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 fire window assemblies per 8.5 Doors are self-closing or automatic closing, do not requilatching, and are not required swing in the direction of egress	e. ns ke e as in ked 5.	04/06/2023

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING 01		01	COMPLETED	
155723		B. W	ING		04/04/	/2023	
NAME OF PROVIDER OR SUPPLIER  RIVER POINTE HEALTH CAMPUS  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE			STREET ADDRESS, CITY, STATE, ZIP COD  3001 GALAXY DR  EVANSVILLE, IN 47715  ID PROVIDER'S PLAN OF CORRECTION (X5)  CEACH CORPORTIVE ACTION SHOULD BE (COLUMN ETRICS)				
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	RIATE COMPLETION DATE	
	hardware. This was facility's Director o observation, who fu latching mechanism This finding was re	s acknowledged by the f Plant Operations at the time of urther said he would fix the n as soon as possible. viewed with the Executive Director's of Plant Operations			travel. Door opening provides minimum clear width of 32 inc for swinging or horizontal doo 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. LSC, Section 8.5.4.1 requires doors in smoke barriers to clo the opening leaving only the minimum clearance necessary proper operation which is defi as 1/8 inch to restrict the movement of smoke.  3. As a measure on ongoin compliance, the Director of Pl. Operations and/or designee we audit smoke barrier doors to we they latch properly 1 x per we three months followed by 1 x month x 3 months.  4. As a quality measure, the results of these inspections we presented by Executive Directing the QAPI committee for further recommendations and continuantil the Quality Assurance Tedetermines substantial compliance has been achieve	a hes rs.  4. se y for ned  gant vill verify ek x per e ill be tor to er ue eam	

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