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	06/24/2024

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: 06/24/24 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 44. Quality Review completed on 06/27/24	E 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 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 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: 06/24/24 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	07/11/2024

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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 44 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 06/27/24		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 0131 SS=E 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 4 sets of 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 latched when tested. 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 at least 10 residents, staff, and visitors. Findings include: Based on observation on 06/24/24 between 1:40 p.m. and 3:30 p.m. during a tour of the facility with the Director of Plant Operations (DPO) and Facility Maintenance Support (FMS), the left side 90 minute rated fire door (second floor, facing the AL hall) near room 533, 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 latch when tested. Based on interview at the time of observation, the DPO said he was aware the door was not latching due to a broken part that happened late last week. He also said the part has been ordered and expected to the facility on the day of this survey.	K 0131	1. No residents were affected by the alleged deficient practice. The part for the fire door was received on 7/2/24 and installed the same day by the Director of Plant Operation. Fire Door is now functioning properly. 2. All residents have the potential to be affected by the alleged deficient practice. The Director of Plant Operations was educated by the Executive Director on K-Tag 131: 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. 3. As a measure of ongoing compliance, the Director of Plant Operations and/or designee will audit the deficient fire door 1 x per week x three months followed by 1 x per month x 3 months.	07/02/2024

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	This finding was reviewed with the Executive Director, DPO, and FMS during the exit conference. 3.1-19(b)		4. As a quality measure, the results of these inspections will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.	
K 0225 SS=E Bldg. 01	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 Based on observation and interview, the facility failed to ensure 1 of 6 stairway enclosure doors was not provided with an impediment to prevent latching. This deficient practice could affect at least 10 residents, staff, and visitors. Findings include: Based on observations on 06/24/24 between 1:40 p.m. and 3:30 p.m. during a tour of the facility with Director of Plant Operations (DPO) and Facility Maintenance Support (FMS), the first floor stairway door near rooms 301 and 302 had a two inch metal screw placed in the door latch which prevented the door from latching. Based on interview, the FMS acknowledged the metal screw in the door latch and removed it immediately. This finding was reviewed with the Executive Director, DPO, and FMS during the exit conference. 3.1-19(b)	K 0225	1. No residents were affected by the alleged deficient practice. Screw was removed and anticipated arrival of the new door latch is 7/17/24 with a date of compliance of 7/24/24. 2. All residents have the potential to be affected by the alleged deficient practice. The Director of Plant Operations was educated by the Executive Director on K-Tag 225: 7.2. LSC Section 7.2.1.5.10 requires a latch or other fastening device on a door leaf to be provided with a releasing device that has an obvious method of operation and is readily operated under all lighting conditions. 3. As a measure of ongoing compliance, the Director of Plant Operations and/or designee will audit the deficient stairway door 1 x per week x three months followed by 1 x per month x 3	07/24/2024

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			months. 4. As a quality measure, the results of these inspections will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.	
K 0353 SS=C Bldg. 01	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, 7.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to document sprinkler system inspections in accordance with NFPA 25 for 1 of 1 dry sprinkler system during 12 of the past 12 months for the sprinkler system's control valves. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states	K 0353	1. No residents were affected by the alleged deficient practice. The Director of Plant Operations has added inspection of sprinkler control valves to his daily routine when he inspects the sprinkler gauges, and it was started on 7/1/24.	07/01/2024

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	gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 06/24/24 between 9:30 a.m. and 1:40 p.m. with the Director of Plant Operations (DPO) and Facility Maintenance Support (FMS) present, there was no monthly sprinkler system control valves inspection documentation for 12 of the past 12 months available to review. Based on interview at the time of record review, the DPO said he does inspect the sprinkler control valves on a daily basis along with the sprinkler gauges, but does not document the control valves as having been inspected. This finding was reviewed with the Executive Director, DPO, and FMS during the exit conference. 3.1-19(b)		2. All residents have the potential to be affected by the alleged deficient practice. The Director of Plant Operations was educated by the Executive Director on K-Tag 353: NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. 3. As a measure of ongoing compliance, the Executive Director and/or designee will audit sprinkler control valve documentation to ensure completion 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 the Executive	

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			Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.	
K 0531 SS=E Bldg. 01	NFPA 101 Elevators Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 Based on record review, observation, and interview; the facility failed to ensure documentation was provided for the testing of 2 of 2 elevators firefighter recall in accordance with 9.4.6, Elevator Testing. LSC 9.4.6.2 states that all elevators with fire fighters' emergency operations in accordance with 9.4.3 shall be subject to a monthly operation with a written record of the	K 0531	1. No residents were affected by the alleged deficient practice. TELS task for firefighter recall updated from quarterly to monthly and completed on 6/28/24. 2. All residents have the potential to be affected by the alleged deficient practice. The Director of	06/28/2024

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	findings made and kept on the premises as required by ASME A17.1/CSA B44, Safety Code for Elevators and Escalators. This deficient practice could affect at least four residents and staff. Findings include: Based on record review on 06/24/24 between 9:30 a.m. and 1:40 p.m. with the Director of Plant Operations (DPO) and Facility Maintenance Support (FMS) present, there was documentation available for the firefighter recall test for the two elevators for the past 12 months, however, the tests were only performed on a quarterly basis. Dates of the quarterly inspections were 07/31/23, 10/26/23, 01/25/24, and 04/29/24. Based on interview at the time of record review, the DPO said the the facility uses TELS and is only instructed to test the firefighter recall on a quarterly basis, but would have it changed to test on a monthly basis. Based on observations on 06/24/24 between 12:40 p.m. and 3:30 p.m. during a tour of the facility with the DPO and FMS both elevators were equipped with a firefighter recall key operation. This was confirmed by the DPO and FMS at the time of each observation. This finding was reviewed with the Executive Director, DPO, and FMS during the exit conference. 3.1-19(b)		Plant Operations was educated by the Executive Director on K-Tag 531: LSC 9.4.6.2 states that all elevators with fire fighters' emergency operations in accordance with 9.4.3 shall be subject to a monthly operation with a written record of the findings made and kept on the premises as required by ASME A17.1/CSA B44, Safety Code for Elevators and Escalators. 3. As a measure of ongoing compliance, the Executive Director and/or designee will audit firefighter recall documentation to ensure compliance 1 x per month x 6 months. 4. As a quality measure, the results of these inspections will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.	
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency.			

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	Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review and interview, the facility failed to provide a complete facility specific written fire safety plan for the protection of all residents to accurately address all life safety systems, plus a system addressing all items required by NFPA 101, 2012 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to:	K 0711	1. No residents were affected by the alleged deficient practice. A campus specific fire emergency plan was added to the facility EOP on 7/10/24 and all staff were sent the plan via our Workrede communication app. 2. All residents have the potential to be affected by the alleged deficient practice. The Director of Plant Operations was educated by the Executive Director on K-Tag 711: NFPA 101, 2012 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire. Section 19.2.3.4(4) states any required aisle or corridor shall not be less	07/10/2024

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	i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants in the event of an emergency. Findings include: Based on a review of the facility's Fire Emergency plan on 06/24/24 between 9:30 a.m. and 1:40 p.m. with the Director of Plant Operations (DPO) and Facility Maintenance Support (FMS) present, the plan did address evacuation of the smoke compartment, however, the plan did not identify where the smoke barriers were located in the facility. Based on interview at the time of record review, the DPO and FMS acknowledged and agreed that the Fire Emergency plan did not identify where the smoke barriers were located in the facility. This finding was reviewed with the Executive Director, DPO, and FMS during the exit conference. 3.1-19(b)		than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment. 3. As a measure of ongoing compliance, the Director of Plant Operations and/or designee will audit the facility fire plan 1 x per month x 6 months. 4. As a quality measure, the results of these inspections will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.	
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			

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	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 fire drills were held at varied times for 3 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 06/24/24 between 9:30 a.m. and 1:40 p.m. with the Director of Plant Operations (DPO) and Facility Maintenance Support (FMS) present, 3 of 4 first shift (day) fire drills were performed between 11:00 a.m. and 11:30 a.m., 3 of 4 second shift (evening) fire drills were performed between 3:52 p.m. and 4:32 p.m., and there were no third shift (night) fire drills performed between 11:41 p.m. and 5:55 a.m. Based on interview at the time of record review, the DPO and FMS acknowledged the times of the first, second, and third shift fire drills were performed and agreed the times were not varied enough. This finding was reviewed with the Executive Director, DPO, and FMS during the exit conference. 3.1-19(b) 3.1-51(c)	K 0712	1. No residents were affected by the alleged deficient practice. A plan for the rest of the year was created on 7/8/24 to ensure that fire drill times are varied throughout all the shifts and at different times. 2. All residents have the potential to be affected by the alleged deficient practice. The Director of Plant Operations was educated by the Executive Director on K-Tag 712: NFPA 101 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. 3. As a measure of ongoing compliance, the Executive Director and/or designee will audit fire drill documentation to ensure compliance 1 x per month x 6 months. 4. As a quality measure, the results of these inspections will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.	07/08/2024

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	155723	A. BUILDING 01 B. WING	06/24/2024

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