PRINTED: 07/15/2024 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155723			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/24/2024	
NAME OF 1	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD		
RIVER P	OINTE HEALTH CA	AMPUS			GALAXY DR GVILLE, IN 47715		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛΤΕ	COMPLETION DATE
E 0000							
Bldg	conducted by the In accordance with 42 Survey Date: 06/24 Facility Number: 0 Provider Number: 201 At this Emergency Pointe Health Camp with Emergency Production Medicare and Mediand Suppliers, 42 Compared to the International Suppliers in International Suppli	02280 155723 068770 Preparedness survey, River ous was found in compliance eparedness Requirements for caid Participating Providers FR 483.73. certified beds. At the time of us was 44.	E 00	000	The submission of this plan of correction does not indicate a admission by River Pointe He Campus that the findings and allegations contained herein a accurate, true representation the living environment provide the residents of River Pointe Health Campus. The facility hereby maintains it is in substantial compliance with a state and federal requirement governing the management of facility. It is thus submitted as matter of statute only. The far respectfully requests from the department a desk review for substantial compliance.	n alth are of ed to II s f this a cility	
K 0000							
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 06/24 Facility Number: 0 Provider Number: AIM Number: 201 At this Life Safety 6	02280 155723 068770 Code survey, River Pointe	K 0	000	The submission of this plan of correction does not indicate a admission by River Pointe He Campus that the findings and allegations contained herein a accurate, true representation the living environment provide the residents of River Pointe Health Campus. The facility hereby maintains it is in substantial compliance with a state and federal requirement	n alth are of ed to	
	Health Campus was	found not in compliance with			governing the management of	i this	I

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

(X6) DATE

governing the management of this

TITLE

Jordan Shots **Executive Director** 07/11/2024

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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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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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		06/24/	2024
				CTREET	DDDECC CITY CTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
		MPLIC			ALAXY DR		
RIVER PO	OINTE HEALTH CA	AMPUS		EVANS	VILLE, IN 47715		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID BROWINED'S BLANGE CORRECT		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 APPROPRIATE	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Requirements for Pa	articipation in			facility. It is thus submitted as	a	
	Medicare/Medicaid,	, 42 CFR Subpart 483.90(a),			matter of statute only. The fac	ility	
	Life Safety from Fir	re and the 2012 edition of the			respectfully requests from the		
	National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.				department a desk review for		
					substantial compliance.		
	1						
	This two story facili	ity was determined to be of					
	_	ruction and was fully					
	* *	cility has a fire alarm system					
	•	oke detectors in the corridors,					
		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.						
	and had a census of	That the time of this survey.					
	All areas where the	residents have customary					
	access were sprinkle	ered. All areas providing					
	facility services wer	re sprinklered.					
	Quality Review con	npleted on 06/27/24					
K 0131	NFPA 101						l
SS=E	Multiple Occupand	cies					
Bldg. 01	· ·	cies - Sections of Health					
J -	Care Facilities						
		care facilities classified as					
		meet all of the following:					
	o Thev are not in	tended to serve four or					
	-	r purposes of housing,					
	treatment, or custo						
		rated from areas of health					
	care occupancies						
	-	aving a minimum two hour					
	fire resistance ratio	_					
	accordance wit						
		ding is protected throughout					
	by an approved, s	· ·					
		ikler system in accordance					
	with Section 9.7.	inter system in accordance					
	with Section 9.7.		1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u>	COMPL	
		155723	B. W	ING		06/24/	/2024
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	ROVIDER OR SUPPLIER	C		3001 G	ALAXY DR		
RIVER P	OINTE HEALTH CA	AMPUS		EVANS	SVILLE, IN 47715		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	Hospital outpatien required to be class Health Care Occu number of patients 19.1.3.3, 42 CFR Based on observation failed to ensure 1 of hour fire separation Living section of the care section of the face section of the face section of the face section rating of or partition shall be labeled fire door assassemblies and their including all frames and sills in accordant NFPA 80, Standard Opening Protective required shall bear a deficient practice of staff, and visitors. Findings include: Based on observation p.m. and 3:30 p.m. of the Director of Plant Facility Maintenance 90 minute rated fire AL hall) near room hour fire wall that section and the skill facility did not lated interview at the time he was aware the debroken part that happens and section and the skill facility did not lated interview at the time he was aware the debroken part that happens and section and the skill facility did not lated interview at the time he was aware the debroken part that happens are patients.	nt surgical departments are ssified as an Ambulatory pancy regardless of the	K 0		1. No residents were affected the alleged deficient practice. part for the fire door was recei on 7/2/24 and installed the sar day by the Director of Plant Operation. Fire Door is now functioning properly. 2. All residents have the potent to be affected by the alleged deficient practice. The Directo Plant Operations was educate the Executive Director on K-Ta 131: LSC 8.3.3.1 states opening required to have a fire protection rating of 1 1/2 hour in a 2 hour wall or partition shall be protect by approved, listed, labeled fir door assemblies and fire wind assemblies and their accompanying hardware, incluall frames, closing devices, anchorage, and sills in accordance with the requirement of NFPA 80, Standard for Fire Doors and Other Opening Protectives. 8.3.3.2.2 states all products required shall bear a approved label. 3. As a measure of ongoing compliance, the Director of Pla Operations and/or designee waudit the deficient fire door 1 x week x three months followed	The The ved wed me Itial r of d by ag ngs on fire cted e ow uding ents Il n ant ill r per	07/02/2024
	facility on the day of	-			x per month x 3 months	, .	

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CENTERS FOR MEDICARE & MEDICAID SERVICES	

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155723	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/24/2024	
	PROVIDER OR SUPPLIER			3001 G	ADDRESS, CITY, STATE, ZIP COD ALAXY DR SVILLE, IN 47715		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
		viewed with the Executive FMS during the exit			4. As a quality measure, the results of these inspections w presented by the Executive Director to the QAPI committe further recommendations and continue until the Quality Assurance Team determines substantial compliance has be achieved.	ee for	
K 0225 SS=E Bldg. 01	Stairways and Sm Stairways and Sm as exits are in acc 18.2.2.3, 18.2.2.4, Based on observation failed to ensure 1 of was not provided w latching. This deficile least 10 residents, so Findings include: Based on observation p.m. and 3:30 p.m. Director of Plant Op Maintenance Suppostairway door near a inch metal screw pl prevented the door interview, the FMS in the door latch and This finding was reconstructed.	, 19.2.2.3, 19.2.2.4, 7.2 on and interview, the facility f 6 stairway enclosure doors ith an impediment to prevent cient practice could affect at	K 0	225	1. No residents were affected the alleged deficient practice. Screw was removed and anticipated arrival of the new latch is 7/17/24 with a date of compliance of 7/24/24. 2. All residents have the potent be affected by the alleged deficient practice. The Director Plant Operations was educate the Executive Director on K-T 225: 7.2. LSC Section 7.2.1.5 requires a latch or other faste device on a door leaf to be provided with a releasing devithat has an obvious method coperation and is readily operationed all lighting conditions. 3. As a measure of ongoing compliance, the Director of Pl Operations and/or designee waudit the deficient stairway do x per week x three months followed by 1 x per month x 3	door Intial or of ed by ag .10 Ining ice If Inted ant will oor 1	07/24/2024

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ľ		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155723	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/24/2024	
	PROVIDER OR SUPPLIER		3001 G	ADDRESS, CITY, STATE, ZIP COD SALAXY 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				months. 4. As a quality measure, the results of these inspections will presented by the Executive Director to the QAPI committe further recommendations and continue until the Quality Assurance Team determines substantial compliance has be achieved.	e for	
K 0353 SS=C Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location ar	- Maintenance and Testing - Maintenance and Testing er and standpipe systems ted, and maintained in IFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, etting are maintained in a and readily available. system last checked				
	coverage for any r automatic sprinkle	supply source RKS information on non-required or partial or system.				
	failed to document accordance with NF system during 12 of sprinkler system's c Standard for the Ins	riew and interview, the facility sprinkler system inspections in FPA 25 for 1 of 1 dry sprinkler in the past 12 months for the control valves. NFPA 25, pection, Testing, and ter-Based Fire Protection	K 0353	1. No residents were affected the alleged deficient practice. Director of Plant Operations h added inspection of sprinkler control valves to his daily rout when he inspects the sprinkle gauges, and it was started on	The as ine	

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Systems, 2011 Edition, Section 5.2.4.2 states

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7/1/24.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155723	B. WING		06/24/2024	
	PROVIDER OR SUPPLIER		3001 G	ADDRESS, CITY, STATE, ZIP COD SALAXY DR SVILLE, IN 47715		
(X4) ID	SIIMMADV	STATEMENT OF DEFICIENCIE	ID ID	1	(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
TAG	·	LISC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	gauges on dry pipe inspected weekly to water pressures are 5.1.2 states valves a connections shall be maintained in accor Section 13.1.1.2 sta utilized for inspectivalves, valve compostates records shall tests, and maintenan components and sha authority having jur deficient practice or and visitors in the farmand to the farmand of the	sprinkler systems shall be ensure that normal air and being maintained. Section and fire department enspected, tested, and dance with Chapter 13. tes Table 13.1.1.2 shall be on, testing and maintenance of conents and trim. Section 4.3.1 be made for all inspections, nee of the system and its all be made available to the risdiction upon request. This build affect all residents, staff,		2. All residents have the poter to be affected by the alleged deficient practice. The Director Plant Operations was educate the Executive Director on K-Ta 353: NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Protection Systems, 2011 Edi Section 5.2.4.2 states gauges dry pipe sprinkler systems shabe inspected weekly to ensure that normal air and water pressures are being maintained Section 5.1.2 states valves and fire department connections sie 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 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 made available to the authorit having jurisdiction upon reques 3. As a measure of ongoing compliance, the Executive Director and/or designee will a sprinkler control valve documentation to ensure completion 1 x per week x thromonths followed by 1 x per months followed by 1 x per months followed by 1 x per months followed by 1 x per months.	ntial or of ed by ag ne Fire tion, on all ee ed. nd hall n and s, m be be y est.	
				4. As a quality measure, the	ill he	

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presented by the Executive

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	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL		
		155723	B. W	ING		06/24/	/2024	
	PROVIDER OR SUPPLIE			3001 G	ADDRESS, CITY, STATE, ZIP COD ALAXY DR			
RIVERP	OINTE HEALTH C	AMPUS		EVANS	VILLE, IN 47715			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					Director to the QAPI committee further recommendations and continue until the Quality Assurance Team determines substantial compliance has be achieved.			
14.0504								
K 0531	NFPA 101							
SS=E Bldg. 01	Elevators							
Blug. 01	Elevators 2012 EXISTING							
		with the provision of 9.4.						
		pected and tested as						
	·	E A17.1, Safety Code for						
	· ·	calators. Firefighter's						
		ed monthly with a written						
	record.	•						
	Existing elevators	conform to ASME/ANSI						
	A17.3, Safety Cod	de for Existing Elevators						
	and Escalators. A	Il existing elevators, having						
	a travel distance	of 25 feet or more above or						
		at best serves the needs of						
		nnel for firefighting						
		n with Firefighter's Service						
	•	ASME/ANSI A17.3.						
	`	er's service Phase I key						
		detector automatic recall,						
	•	e Phase II emergency in-car						
		achine room smoke						
		evator lobby smoke						
	detectors.) 19.5.3, 9.4.2, 9.4.	3						
		view, observation, and	K 0	521	No residents were affected	hv	06/20/2024	
	interview; the facili		K 0	J31	the alleged deficient practice.	Бу	06/28/2024	
		provided for the testing of 2			TELS task for firefighter recall			
		ghter recall in accordance with			updated from quarterly to mor			
		ting. LSC 9.4.6.2 states that all			and completed on 6/28/24.	y		
	· ·				2. All residents have the poter	ntial		
	elevators with fire fighters' emergency operations in accordance with 9.4.3 shall be subject to a				to be affected by the alleged			
		with a written record of the			deficient practice. The Directo	or of		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	ETED
		155723	B. W	ING		06/24/	2024
				CTREET	ADDRESS SITE STATE SID COD		
NAME OF F	PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
DI) (ED D		MELLO			ALAXY DR		
RIVERP	OINTE HEALTH CA	AMPUS		EVANS	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		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	findings made and l	kept on the premises as			Plant Operations was educate	d by	
	required by ASME	A17.1/CSA B44, Safety Code			the Executive Director on K-Ta	ag	
	for Elevators and E	scalators. This deficient			531: LSC 9.4.6.2 states that a	II	
	practice could affec	t at least four residents and			elevators with fire fighters'		
	staff.				emergency operations in		
					accordance with 9.4.3 shall be	;	
	Findings include:				subject to a monthly operation	ı	
					with a written record of the fine		
	Based on record rev	view on 06/24/24 between 9:30			made and kept on the premise	-	
	a.m. and 1:40 p.m.	with the Director of Plant			as required by ASME A17.1/C	SA	
	Operations (DPO) a	and Facility Maintenance			B44, Safety Code for Elevator	s	
	Support (FMS) pres	sent, there was documentation			and Escalators.		
	available for the fire	efighter recall test for the two			3. As a measure of ongoing		
	elevators for the pas	st 12 months, however, the			compliance, the Executive		
	tests were only perf	ormed on a quarterly basis.			Director and/or designee will a	audit	
	Dates of the quarter	ly inspections were 07/31/23,			firefighter recall documentation	n to	
	10/26/23, 01/25/24,	and 04/29/24. Based on			ensure compliance 1 x per mo	onth	
	interview at the tim	e of record review, the DPO			x 6 months.		
		uses TELS and is only			4. As a quality measure, the		
		e firefighter recall on a			results of these inspections wi	ll be	
		would have it changed to test			presented by the Executive		
	· ·	Based on observations on			Director to the QAPI committe	e for	
		2:40 p.m. and 3:30 p.m. during a			further recommendations and		
	· ·	vith the DPO and FMS both			continue until the Quality		
		pped with a firefighter recall			Assurance Team determines		
		s was confirmed by the DPO			substantial compliance has be	en	
	and FMS at the time	e of each observation.			achieved.		
	_	viewed with the Executive					
		FMS during the exit					
	conference.						
	3.1-19(b)						
14 0744	 						
K 0711	NFPA 101						
SS=F	Evacuation and R						
Bldg. 01	Evacuation and R						
		plan for the protection of all					
	I '	eir evacuation in the event					
	of an emergency.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	
		155723	B. Wl	ING		06/24	/2024
	PROVIDER OR SUPPLIER		<u>, </u>	3001 G	ADDRESS, CITY, STATE, ZIP COD ALAXY DR SVILLE, IN 47715	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWINEDIS DI AM OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	\\\L	DATE
	Employees are perkept informed with and a copy of the with telephone opplan addresses the of staff per 18/19. Of the fire safety per 18/19.2.2. 18.7.1.1 through 18.7.2.2, 18.7.2.3, 19.7.2.1.2, 19.7.2.1.2. Based on record reversided to provide a comparison of the fire safety per residents to accurate systems, plus a system, plus a syst	riodically instructed and a their duties under the plan, plan is readily available erator or with security. The e basic response required 7.2.1.2 and provides for all plan components per 18.7.1.3, 18.7.2.1.2, 19.7.1.1 through 19.7.1.3, 19.7.2.3 where and interview, the facility complete facility specific plan for the protection of all ely address all life safety tem addressing all items 101, 2012 edition, Section 19.2.2 requires a written health care try plan that shall provide for a plan that shall provide for 19.2.2 requires a written health care try plan that shall provide for 19.2.3 where a plan that shall provide for 19.3 and building for 19.3 as means of egress from 19	K 0		1. No residents were affected the alleged deficient practice. campus specific fire emergence plan was added to the facility on 7/10/24 and all staff were sto the plan via our Workrede communication app. 2. All residents have the potent to be affected by the alleged deficient practice. The Director Plant Operations was educated the Executive Director on K-Tatl: 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: Use of alarms (2) Transmissionalarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area Evacuation of smoke compart (8) Preparation of floors and building for evacuation (9) Extinguishment of fire. Section 19.2.3.4(4) states any requires aisle or corridor shall not be less that the same control of the section 19.2.3.4(4) states any requiremants.	A cy EOP sent ntial or of ed by ag t (1) on of	07/10/2024

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 06/24/2024 155723 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3001 GALAXY DR RIVER POINTE HEALTH CAMPUS **EVANSVILLE, IN 47715** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE i. Equipment in use and carts in use than 48 inches in clear width ii. Medical emergency equipment not in use where serving as means of egress iii. Patient lift and transport equipment from patient sleeping rooms. This deficient practice could affect all occupants Projections into the required width in the event of an emergency. shall be permitted for wheeled equipment provided the relocation Findings include: of wheeled equipment during a fire or similar emergency is addressed Based on a review of the facility's Fire Emergency in the written fire safety plan and plan on 06/24/24 between 9:30 a.m. and 1:40 p.m. training program for the facility. with the Director of Plant Operations (DPO) and The wheeled equipment is limited Facility Maintenance Support (FMS) present, the to: i. Equipment in use and carts plan did address evacuation of the smoke in use ii. Medical emergency compartment, however, the plan did not identify equipment not in use iii. Patient lift where the smoke barriers were located in the and transport equipment. facility. Based on interview at the time of record 3. As a measure of ongoing review, the DPO and FMS acknowledged and compliance, the Director of Plant agreed that the Fire Emergency plan did not Operations and/or designee will identify where the smoke barriers were located in audit the facility fire plan 1 x per the facility. month x 6 months. 4. As a quality measure, the This finding was reviewed with the Executive results of these inspections will be Director, DPO, and FMS during the exit presented by the Executive conference. Director to the QAPI committee for further recommendations and 3.1-19(b) continue until the Quality Assurance Team determines substantial compliance has been achieved. K 0712 **NFPA 101** SS=C Fire Drills Bldg. 01 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.

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The staff is familiar with procedures and is aware that drills are part of established

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	
		155723	B. Wl	NG		06/24/	2024
	PROVIDER OR SUPPLIER		•	3001 G	ADDRESS, CITY, STATE, ZIP COD ALAXY DR SVILLE, IN 47715		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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'	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	routine. Where dr 9:00 PM and 6:00 announcement ma audible alarms. 19.7.1.4 through 1 Based on record revialled to ensure fire for 3 of 3 employee This deficient practithe facility. Findings include: Based on review of on 06/24/24 betwee the Director of Plan Facility Maintenance 4 first shift (day) fire between 11:00 a.m. shift (evening) fire 3:52 p.m. and 4:32 shift (night) fire drill p.m. and 5:55 a.m. of record review, the acknowledged the tithird shift fire drills times were not varied.	AM, a coded ay be used instead of 19.7.1.7 View and interview, the facility drills were held at varied times shifts during 4 of 4 quarters. ice could affect all residents in 15. The facility's fire drill reports in 9:30 a.m. and 1:40 p.m. with at Operations (DPO) and ite Support (FMS) present, 3 of ite drills were performed and 11:30 a.m., 3 of 4 second drills were performed between p.m., and there were no third ills performed between 11:41 Based on interview at the time is dependent of the first, second, and it were performed and agreed the	K 0		1. No residents were affected the alleged deficient practice. In plan for the rest of the year was created on 7/8/24 to ensure the fire drill times are varied throughout all the shifts and at different times. 2. All residents have the potent to be affected by the alleged deficient practice. The Director Plant Operations was educate the Executive Director on K-Ta 712: NFPA 101 Fire drills inclute 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 of each shift. 3. As a measure of ongoing compliance, the Executive Director and/or designee will a fire drill documentation to ensure compliance 1 x per month x 6 months. 4. As a quality measure, the results of these inspections will presented by the Executive Director to the QAPI committee further recommendations and continue until the Quality Assurance Team determines substantial compliance has be achieved.	tial tof d by ag ide n udit ure	07/08/2024

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/15/2024 FORM APPROVED OMB NO. 0938-039

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155723	` ′	ILDING	nstruction <u>01</u>	(X3) DATE COMPL 06/24 /	ETED
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	(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)	TE	(X5) COMPLETION DATE

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