STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155669	A. BUILDING 02 B. WING	09/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW TCU	395 WESTFIELD RD TCU NOBLESVILLE, IN 46060

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K 0000 Bldg. 02	A Life Safety Code Recertification and a State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/14/17 Facility Number: 011046 Provider Number: 155669 AIM Number: NA At this Life Safety Code survey, Riverview TCU was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(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 facility is located on the fourth floor of a fully sprinklered five story building with a basement. This facility was determined to be of Type I (332) construction. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all 13	K 0000	Preparation and /or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and /or executed in compliance with state and federal laws. The plan of correction constitutes our Credible Allegation of compliance with all regulatory requirements. This provider requests A Desk Review in lieu of a Post Survey revisit. (See the attached documentation to support a desk review) Our Date of compliance is: 10/11/2017	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	resident sleeping rooms. The facility has a capacity of 25 and had a census of 12 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 09/22/17 - DA			
K 0211 SS=B Bldg. 02	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 1 corridor means of egress was continuously maintained and free of obstructions. This deficient practice affects as many as 4 residents, as well as staff and visitors. Findings include: Based on observations with the Administrator and the Operations Director during a tour of the facility on 09/14/2017 from 11:30 a.m. to 1:00 p.m.,	K 0211	K 211 It is the practice of this provider to abide by NFPA 101 Regarding Means of Egress for Aisles, passageways and exit corridors. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	10/11/2017

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	the hall outside resident rooms #4412 and #4413 had isolation cabinets sitting immediately outside the resident room doors. These cabinets were approximately 18 inches in lenght by 18 inches wide by 24 inches high, were not on wheels, and were stored in the corridor there per staff. Based on interview with the Administrator and the Operations Director, the cabinets were stored in the corridor to allow staff quick access to them before entering the resident rooms. The storage of the contact isolation cabinets in the corridor was verified by the Administrator and the Operations Director at the time of the observation. 3.1-19(b)		·New isolation carts, with wheels, were ordered and received. These carts are in use, as needed, and have replaced the previous isolation carts. **How will other patients having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** ·All patients located on the 4th floor have the potential to be affected by this alleged practice if we have patients in isolation. Previous isolation patients have been discharged and there are no current patients in Isolation. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** The Administrator/designee will complete environmental audits 5 times per week for 30 days, then 5 times per month for 150 days then monthly thereafter for total of 12 months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality	

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			assurance program will be put into place Results of audit findings will be reported to the QA committee monthly for 12 months.. If 100% compliance is not maintained an action plan will be developed. After 12 months compliance the QA committee will determine the frequency of continued monitoring. **What date the systemic changes will be completed:** Systemic corrections will be completed by October 11, 2017	
K 0225 SS=F Bldg. 02	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 provide a continuous protected path of travel to an exit discharge for 3 of 3 exits in accordance with LSC sections 7.2.3.5. LSC 7.2.3.5.1 requires every smoke proof enclosure shall discharge into a public way, into a	K 0225	K 225 It is the practice of this provider to abide by the Life Safety Code determined appropriate for this Unit.	10/17/2017

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	yard or court having direct access to a public way, or into an exit passageway. Such exit passageways shall be without openings other than the entrance from the smoke proof enclosure and the door to the outside yard, court, or public way. The exit passageway shall be separated from the remainder of the building by a two hour fire resistance rating. This deficient practice affects all residents, staff and visitors. Findings include: Based on observations with the Administrator and the Operations Director during a tour of the facility from 11:30 a.m. to 1:00 p.m. on 09/14/17, the fourth floor on which the TCU is located is divided into two smoke compartments and has three stairwell exits. Additionally, the fire resistance rating of the three exit enclosures on the first floor of the hospital to the exit discharge door is less than two hours. Based on interview at the time of the observations, the Administrator and the Operations Director acknowledged each of the three exit discharge passageways are not separated from the remainder of the building by a two hour fire resistance rating. 3.1-19(b)		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·This provider completed an assessment by Fire Safety Evaluation System (FSES to demonstrate equivalent compliance. (See attached FSES survey) **How will other patients having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** ·All patients located on the 4th floor have the potential to be affected by this alleged practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** FSES audit will be completed when structural changes are	

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			made to the Unit How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place The Hospital will update the FSES survey/audit when any life safety structural changes are made to this area **What date the systemic changes will be completed:** With acceptance of the FSES survey/audit, systemic corrections will be completed by October 11,2017 Resubmission K-0225 Revised FSES has been completed and is attached. This revised FSES addresses the scoring of Zone Dimensions and Emergency Movement Routes. In addition scoring was changed from existing hospital (form 4.7.8A) to existing Nursing Home. (form 4.7.8B) With acceptance of the revised	

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			FSES systemic corrections will be completed by October 17, 2017.	
K 0252 SS=F Bldg. 02	NFPA 101 Number of Exits - Corridors Number of Exits - Corridors Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4 Based on observation and interview, the facility failed to ensure 2 of 2 smoke compartments were provided with at least one exit providing a continuous path of travel to an exit discharge. This deficient practice affects all residents, staff and visitors. Findings include: Based on observations with the Administrator and the Operations Director during a tour of the facility from 11:30 a.m. to 1:00 p.m. on 09/14/17, the TCU has two emergency exits. One exit is a horizontal exit into the adjacent smoke compartment. The adjacent smoke compartment has two exit stairwells. The second exit is an exit stairwell which does not connect to an exit discharge directly to the exterior. Based on interview at the time of the observations, the Administrator and the Operations	K 0252	**K 252** It is the practice of this provider to abide by the Life Safety Code determined appropriate for this Unit. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·This provider completed an assessment by Fire Safety Evaluation System (FSES to demonstrate equivalent compliance. (See attached FSES survey) **How will other patients having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken**	10/17/2017

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	Director acknowledged each smoke compartment is not provided with at least one exit discharging directly to the exterior of the building. 3.1-19(b)		·All patients located on the 4th floor have the potential to be affected by this alleged practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur FSES audit will be completed when structural changes are made to the Unit How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place The Hospital will update the FSES survey/audit when any life safety structural changes are made to this area What date the systemic changes will be completed: With acceptance of the FSES survey/audit, systemic corrections will be completed by October 11, 2017 **Resubmission for K 0252** **Revised FSED has been completed and is attached.**	

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			This revised FSES addresses the scoring of Zone Dimensions and Emergency Movement Routes. **In addition Scoring was changed from Existing hospital (form 4.7.8A) to Existing Nursing Home (4.7.8B).** **With acceptance of the revised FSES systemic corrections will be completed by October 17, 2017**	
K 0353 SS=F Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview,	K 0353	K 353	10/17/2017

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	the facility failed to ensure 1 of 1 automatic sprinkler piping systems was examined for internal obstructions where conditions exist that could cause obstructed piping as required by NFPA 25, 2011 Edition, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, NFPA 25, 2011 Edition at 14.1 says this chapter shall provide the minimum requirements for conducting investigations of fire protection system piping for possible sources of materials that could cause pipe blockage. NFPA 25, 14.2.1 states an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. Alternative nondestructive examination methods shall be permitted. Non-metallic pipe shall not be required to be inspected internally. NFPA 25, 14.2.2 says in buildings with multiple wet pipe systems, every other system shall have an internal inspection of piping very 5 years as described in 14.2.1. This deficient practice affects all residents, staff and visitors. Findings include:		It is the practice of this provider to abide by the requirement for the Automatic Water-Based Sprinkler System maintenance and testing according with NFPA 25. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Per the findings from ISDH surveyor documentation of maintenance and testing of the Automatic Sprinkler systems according to NFPA 25 was not readily available. It was noted that pictures were taken of different branch lines each year to check for debris and blockage. These pictures were available to provide evidence that the system was meeting standards. An internal pipe evaluation has been completed. (See the attached evaluation) A reoccurring inspection will be scheduled at least every 5 years. **How will other patients having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** ·All patients located on the 4th	

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	Based on observations with the Administrator and the Operations Director during a tour of the facility from 11:30 a.m. to 1:00 p.m. on 09/14/17, there was no copy of the last sprinkler internal pipe investigation available for review. Documentation was available to show that an internal pipe investigation was done by Dalmatian Fire Inc., but a physical copy of the inspection could not be provided for review. The Operations Director did advise that the maintenance department took a different branch line apart each year to check for debris and blockage, so he did not think an internal pipe investigation needed to be completed. The inability to provide a recent copy of an internal pipe investigation was acknowledged by both the Administrator and the Operations Director at the time of the observation. 3.1-19(b)		floor have the potential to be affected by this alleged practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** ·Arrangements have been made to have a company complete the internal pipe investigation at least every 5 years. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place ·The Hospital will review this arrangement annually to insure pipe inspection is completed at least every 5 years which will meet the intent of the NFPA standards. **What date the systemic changes will be completed:**	

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			·With acceptance of this action plan all measures will be completed by October 11, 2017. **Resubmission K 353** **A detailed Pipe inspection report was complete on October 5, 2017. The completed report is attached. This report shows that the pipes for the sprinkler system passed this inspection.** **This 5 year inspection was added to the preventative maintenance calendar to insure that the inspection is completed timely.** **With the acceptance of this resubmission and this complete Pipe inspection all measures will be completed by October 17, 2017**	