STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155165	A. BUILDING -- B. WING	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVERVIEW VILLAGE	586 EASTERN BLVD CLARKSVILLE, IN 47129

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 06/26/24 Facility Number: 000082 Provider Number: 155165 AIM Number: 100289640 At this Emergency Preparedness survey, Riverview Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 130 certified beds. At the time of the survey, the census was 93. The requirement at 42 CFR, Subpart 483.73 is MET. Quality Review completed on 06/28/24	E 0000	Please accept this plan of correction as the facility's credible allegation of compliance for LIFE SAFETY ANNUAL SURVEY dated June 26, 2024. **Please note facility respectfully requests paper compliance review for this survey.**	
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: 06/26/24 Facility Number: 000082 Provider Number: 155165 AIM Number: 100289640	K 0000	Please accept this plan of correction as the facility's credible allegation of compliance for LIFE SAFETY ANNUAL SURVEY dated June 26, 2024. **Please note facility respectfully requests paper compliance review for this survey.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tina Martin	Executive Director	07/11/2024

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	At this Life Safety Code survey, Riverview Village was found not in compliance with 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 fully sprinkled. The facility has a fire alarm system with smoke detection on both levels including the corridors and spaces open to the corridors, plus battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 130 and had a census of 93 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except the detached laundry building. Quality Review completed on 06/28/24			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other Based on observation and interview, the facility failed to maintain the metal rating label on the smoke doors in the F hall, E hall and B hall per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect all staff, residents, and visitors in these smoke compartments. Findings include:	K 0100	**K-100 (E) General Requirements-Other** **1.It is the practice of this facility to maintain the metal rating labels on smoke doors. No specific resident has been affected.** **2. All residents residing on F hall, E hall and B hall have the potential to be affected.** **The metal fire rating labels will**	07/26/2024

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	Based on observation during a tour of the facility on 06/26/24 between 12:30 PM and 3:00 PM with the Maintenance Director and the Regional Maintenance Supervisor, the smoke doors in halls F, E, and B had the fire rating labels painted over. Based on interview at the time of the observation, the Maintenance Director and the Regional Maintenance Supervisor agreed the fire rating labels were painted over on the smoke doors in halls F, E, and B. This finding was reviewed with the Executive Director, Maintenance Director, and Regional Maintenance Supervisor at the exit conference. 3.1-19(b)		**have paint removed from F hall, E hall and B hall doors. 100% check of all doors has been completed and there are no other doors identified that have paint over the metal fire rating label.** **3. Any painting projects will be inspected by the Maintenance Director to ensure fire rating labels are visible.** **4. Fire Rating labels will be monitored monthly through the preventative maintenance program to ensure they remain paint free. The results of the checks will be reported monthly to the Executive Director and presented during facilities monthly QAPI meeting. This will be an ongoing Practice.**	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 supply/clean linen rooms by the B hall nurses' station. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and causes the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect all residents, staff, and visitors in the vicinity of	K 0353	**K-353 Sprinkler System and Testing** **1. No specific resident identified as being affected.** **2. This has the potential to affect all residents, staff, and visitors in the vicinity of the supply/clean linen room. The 0.5 inch penetration around the identified sprinkler escutcheon has been repaired. 100% check of all sprinkler head escutcheon's will be checked to ensure no**	07/26/2024

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	the supply/clean linen room Findings include: Based on observation during a tour of the facility on 06/26/24 between 12:30 PM and 3:00 PM with the Maintenance Director and the Regional Maintenance Supervisor, there was a 0.5 inch penetration around the sprinkler escutcheon in the ceiling of the supply/clean linen room by the B hall nurses' station. Based on interview at the time of the observation, the Maintenance Director agreed there was a penetration in the ceiling in the aforementioned room and provided the measurements. This finding was reviewed with the Executive Director, Maintenance Director, and the Regional Maintenance Supervisor at the exit conference. 3.1-19(b)		**additional penetrations are present.** **3. Any construction completed will be inspected by the maintenance director to ensure there is no penetration around sprinkler escutcheons in the ceiling.** **4. 100% checks will be completed on sprinkler escutcheon's weekly to ensure no penetrations has developed for 1 month, then monthly as an ongoing practice. Results will be reported during the facility QAPI Committee Meeting and to the Executive Director monthly.**	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of 1 medical records offices on the second floor and 1 of 1 housekeeping rooms on the first floor were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect Findings include: Based on observation during a tour of the facility on 06/26/2024 between 12:30 PM and 3:00 PM with the Maintenance Director and Regional Maintenance Director, the door to the first floor	K 0363	**K-363 Corridor- Doors** **1. No specific resident identified. The Housekeeping door had bungee cord immediately removed and housekeeper educated.** **2. All residents residing on the main Hallway have potential to be affected. No residents reside on Medical Records Hallway, but it would have the potential to affect staff.** **3. The Medical Records door had door stop removed and education provided. All-staff**	07/26/2024

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	housekeeping room had a self-closing mechanism, but was being held open by a bungee cord wrapped around the door handle. Based on interview at the time of interview, the Maintenance Director and Regional Maintenance Supervisor agreed the door was being held open with a bungee cord and briefly spoke with the housekeeping staff while removing the bungee cord. Housekeeping Staff A reported to the Maintenance Director and Regional Maintenance Supervisor she was not previously aware the door could not be propped open. Additionally, the medical records office door was also equipped with a self-closing device, but was being propped open. Based on interview at the time of the observation, the Maintenance Director and Regional Maintenance Supervisor agreed the door was propped open and removed the object at the time of observation. The Regional Maintenance Supervisor explained to Medical Records Staff A and the staff member reported the Executive Director had informed her that the door was permitted to be propped open if someone was inside the room. This finding was reviewed with the Executive Director, Maintenance Director, and the Regional Maintenance Supervisor at the exit conference. 3.1-19(b)		**in-service is scheduled for 7/10/24 that will include education in regard to propping open doors.** **4. The Maintenance Director/Designee will monitor doors daily to ensure none are propped open during daily rounds M-F for 1 month. The results of these rounds will be reported during facility QAPI meeting and Executive Director monthly.**	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure 1 of 1 kitchen smoke barrier doors would close to form a smoke resistant barrier. This deficient practice could affect residents, staff and visitors in the Main Dining Room.	K 0374	**K-374 Subdivision of Building Spaces-Smoke Barrier Doors** **1. No specific resident identified. A door closing coordinator will be added to identified doors to ensure**	07/26/2024

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	Findings include: Based on observation during a tour of the facility on 06/26/24 between 12:30 PM and 3:00 PM with the Maintenance Director and the Regional Maintenance Supervisor, the set of smoke barrier doors serving as the entrance to the kitchen near the dietary manager's office both swing in the same direction with the left door equipped with an astragal. The door set was not equipped with a door closing coordinator to ensure the door equipped with an astragal closes last and forms a smoke resistant barrier. Based on interview at the time of observation, the Maintenance Director and Regional Maintenance Supervisor agreed the aforementioned smoke barrier door set was not equipped with a door closing coordinator to ensure the door equipped with an astragal closes last and forms a smoke resistant barrier. This finding was reviewed with the Executive Director, Maintenance Director, and Regional Maintenance Supervisor at the exit conference. 3.1-19(b)		**doors equipped with an astragal closes last and form a smoke resistant barrier.** **2. This has the potential to affect residents, staff, and visitors in the Main Dining Room. 100% smoke barrier doors have been checked to ensure proper closure. No other doors identified.** **3. A door closing coordinator will be added to identified doors to ensure that the door equipped with an astragal closes last and forms a smoke resistant barrier.** **4. The Maintenance Director/Designee will conduct weekly checks to ensure all smoke barrier doors are closing correctly weekly for 1 month then monthly as an ongoing practice. Results of these checks will be reported during facility QAPI meeting and to Executive Director monthly.**	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Based on record review, observation and interview, the facility failed to ensure the metal container with a self-closing cover into which ashtrays can be emptied of noncombustible material and safe design was free of combustible material in the B hall smoking area. This deficient practice could affect residents, staff, and visitors in this smoking area.	K 0741	**K-741 Smoking Regulations** **1. No Specific resident has been identified as being affected. Maintenance Director immediately removed mask from the red butt can.** **2. All residents utilizing B Hall smoking area have the potential to be affected.**	07/26/2024

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	Findings include: Based on observation during a tour of the facility on 06/26/24 between 12:30 PM and 3:00 PM with the Maintenance Director and the Regional Maintenance Director, a disposable mask was observed in the red metal container with a self-closing cover into which ashtrays can be emptied of noncombustible material and safe design in the B hall smoking area. Based on interview at the time of observation, the Maintenance Director agreed there was a disposible mask in the container and removed the item. The Regional Maintenance Supervisor reported he and the Maintenance Director had ensured all metal container with a self-closing cover into which ashtrays can be emptied of noncombustible material and safe design were free of combustible materials earlier in the day. This finding was reviewed with the Executive Director, the Maintenance Director, and the Regional Maintenance Supervisor at the exit conference. 3.1-19(b)		**3. All staff in-service is scheduled for 7/10/24 that will include education regarding proper disposal of combustible items.** **4. Maintenance Director/Designee will complete daily checks on all metal containers with a self-closing cover to be free from combustible material. This will be an ongoing practice, and results will be reported during the facility QAPI meeting and to the Executive Director Monthly.**	