STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155669	A. BUILDING -- B. WING	06/18/2019

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

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 06/18/19 Facility Number: 011046 Provider Number: 155669 AIM Number: NA At this Emergency Preparedness survey, Riverview TCU was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 25 certified beds. At the time of the survey, the census was 9. Quality Review completed on 06/24/19	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and a State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/18/19 Facility Number: 011046 Provider Number: 155669 AIM Number: NA At this Life Safety Code survey, Riverview TCU was found not in compliance with Requirements	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.	

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

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	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 facility is located on the fourth floor of a fully sprinklered five story building. 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 resident sleeping rooms. The facility has a capacity of 25 and had a census of 9 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 06/24/19		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: (Note: In supporting documents duplicate attachments were sent for Drawings #1 and #2 by mistake) 7/6/2019	
K 0225 SS=F 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 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 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	K 0225	K 225 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**	07/06/2019

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	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 on 06/18/19 at 12:50 p.m. with the Director of T.C.U. and the Engineering Supervisor, 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 Director of T.C.U. and the Engineering Supervisor acknowledged each of the three exit discharge passageways are not separated from the remainder of the building by a two hour fire resistance rating. The Engineering Supervisor stated that they (the facility) had an F.S.E.S. for this deficient practice, and that it would be submitted with their plan of correction. 3.1-19(b)		**practice?** · This provider completed an assessment by Fire Safety Evaluation System (F.S.E.S. to demonstrate equivalent compliance. (See attached F.S.E.S. 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** F.S.E.S. 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 F.S.E.S. survey/audit when any life safety structural changes are made to this area or annually to	

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			demonstrate equivalent compliance. **What date the systemic changes will be completed:** With acceptance of the F.S.E.S. survey/audit, systemic corrections will be completed by July 6, 2019	
K 0252 SS=F Bldg. 01	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 on 06/18/19 at 12:52 p.m. with the Director of T.C.U. and the Engineering Supervisor, 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 Director of T.C.U. and the Engineering Supervisor acknowledged each smoke compartment is not provided with at least one exit discharging directly	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 (F.S.E.S. to demonstrate equivalent compliance. (See attached F.S.E.S. survey) **How will other patients having**	07/06/2019

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	to the exterior of the building. The Engineering Supervisor then stated that they (the facility) had an F.S.E.S. for this deficient practice, and that it would be submitted with their plan of correction. 3.1-19(b)		**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** F.S.E.S. 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 F.S.E.S. survey/audit when any life safety structural changes are made to this area or annually to demonstrate equivalent compliance. **What date the systemic changes will be completed:** With acceptance of the F.S.E.S. survey/audit, systemic corrections will be completed by July 6, 2019	

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