PRINTED: 07/09/2019 FORM APPROVED

ENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155669			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/18/2019	
	PROVIDER OR SUPPLIE	R	STREET 395 WE NOBLE			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY 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 APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
E 0000 Bldg	conducted by the In Health in accordant Survey Date: 06/1 Facility Number: 06/1 Provider Number: AIM Number: NA At this Emergency Riverview TCU was Emergency Prepare Medicare and Medicare and Medicare and Suppliers, 42 C	Preparedness survey, as found in compliance with edness Requirements for icaid Participating Providers CFR 483.73 certified beds. At the time of	E 0000			
K 0000 Bldg. 01	A Life Safety Code	011046 155669	K 0000	Preparation and /or execution this plan of correction in gener or this corrective action in particular, does not constitute admission of agreement by thi 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.	al, an s	

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

At this Life Safety Code survey, Riverview TCU

was found not in compliance with Requirements

TITLE

with state and federal laws.

(X6) DATE

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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155669		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/18/2019			
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 395 WESTFIELD RD TCU NOBLESVILLE, IN 46060				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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)	Bitte		
	Subpart 483.90(a), 2012 edition of the Association (NFPA Chapter 19, Existing 410 IAC 16.2 This facility is local sprinklered five stord determined to be of facility has a fire all detection in the corridor. The fasmoke detectors ins sleeping rooms. The and had a census of All areas where residence were sprinklered an services were sprinklered an services were sprinklered and the Association of the corridor.	Medicare/Medicaid, 42 CFR Life Safety from Fire and the National Fire Protection) 101, Life Safety Code (LSC), g Health Care Occupancies and led on the fourth floor of a fully ry building. This facility was Type I (332) construction. The farm system with smoke ridors and in all areas open to cility has battery operated talled in all 13 resident le facility has a capacity of 25 led at the time of this visit. dents have customary access d all areas providing facility clered. Impleted on 06/24/19		The plan of correction constitution our Credible Allegation of compliance with all regulatory requirements. This provider requests A Desi Review in lieu of a Post Surverevisit. (See the attached documentation to support a direview) Our Date of compliaries: (Note: In supporting document duplicate attachments were storn Drawings #1 and #2 by mistake) 7/6/2019	k ey esk nce		
K 0225 SS=F 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 provide a ctravel to an exit disaccordance with LS 7.2.3.5.1 requires exhall discharge into court having direct an exit passageway be without opening the smoke proof encourt exits and stairs are stairly assageway.	okeproof Enclosures okeproof enclosures okeproof enclosures used ordance with 7.2. 19.2.2.3, 19.2.2.4, 7.2 on and interview, the facility continuous protected path of charge for 3 of 3 exits in C sections 7.2.3.5. LSC very smoke proof enclosure a public way, into a yard or access to a public way, or into Such exit passageways shall s other than the entrance from closure and the door to the or public way. The exit	K 0225	K 225 It is the practice of this provide abide by the Life Safety Code determined appropriate for this Unit. What corrective action(s) will be accomplished for those residents found to have bee affected by the deficient	is II		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			01	COMPLETED	
155669		B. WING 06/18/2019					
NAME OF PROVIDER OR SUPPLIER RIVERVIEW TCU			STREET ADDRESS, CITY, STATE, ZIP COD 395 WESTFIELD RD TCU NOBLESVILLE, IN 46060				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOWIDEDIC DI AN OF CORDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	тс	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.16	DATE
		e separated from the remainder			practice?		
		two hour fire resistance					
	_	nt practice affects all residents,		· This provider completed an		d an	
	staff and visitors.				assessment by Fire Safety		
					Evaluation System (F.S.E.S. to		
	Findings include:				demonstrate equivalent		
	D 1 1 .:	06/10/10 + 12.50			compliance. (See attached		
		ons on 06/18/19 at 12:50 p.m. T.C.U. and the Engineering			F.S.E.S. survey)		
		th floor on which the TCU is			How will other patients havir	, l	
		nto two smoke compartments			the potential to be affected b	-	
		rell exits. Additionally, the fire			the same deficient practice v	-	
		the three exit enclosures on			be identified and what	····	
	_	hospital to the exit discharge			corrective action will be take	n	
	door is less than two	o hours. Based on interview at					
	the time of the obse	rvations, the Director of			·All patients located on the 4	ŀth	
	T.C.U. and the Eng	ineering Supervisor			floor have the potential to be		
	-	of the three exit discharge t separated from the			affected by this alleged practic	ce.	
		ilding by a two hour fire			What measures will be put ir	nto	
		ne Engineering Supervisor			place or what systemic		
	_	facility) had an F.S.E.S. for			changes you will make to		
	this deficient practic	ce, and that it would be			ensure that the deficient		
	submitted with their	r plan of correction.			practice does not recur		
	3.1-19(b)				F.S.E.S. audit will be complete	ed	
					when structural changes are r	nade	
					to the Unit		
					How the corrective action(s) w		
					monitored to ensure the defici		
					practice will not recur, i.e., who		
					quality assurance program will put into place	ı De	
					put liito piace		
					The Hospital will update the		
					F.S.E.S. survey/audit when ar	-	
					life safety structural changes a		
					made to this area or annually	to	

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155669	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/18/2019
NAME OF I	PROVIDER OR SUPPLIEF		395 WI	ADDRESS, CITY, STATE, ZIP COD ESTFIELD RD TCU ESVILLE, IN 46060	
(X4) ID PREFIX TAG	(EACH DEFICIEN		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	NFPA 101 Number of Exits - Corridors 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		PREFIX	demonstrate equivalent compliance. What date the systemic changes will be completed: With acceptance of the F.S.E survey/audit, systemic correct will be completed by July 6, 2 It is the practice of this provide abide by the Life Safety Code determined appropriate for this Unit.	07/06/2019
	with the Director of Supervisor, the TCV One exit is a horizo smoke compartment compartment has tweit is an exit stairvan exit discharge di interview at the tim Director of T.C.U.	ons on 06/18/19 at 12:52 p.m. ET.C.U. and the Engineering J has two emergency exits. Intal exit into the adjacent t. The adjacent smoke or exit stairwells. The second well which does not connect to rectly to the exterior. Based on the off the observations, the and the Engineering Supervisor smoke compartment is not		What corrective action(s) wibe accomplished for those residents found to have bee affected by the deficient practice? This provider complete assessment by Fire Safety Evaluation System (F.S.E.S. demonstrate equivalent compliance. (See attached F.S.E.S. survey)	d an

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provided with at least one exit discharging directly

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How will other patients having

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NAME OF PROVIDER OR SUPPLIER RIVERVIEW TCU			STREET ADDRESS, CITY, STATE, ZIP COD 395 WESTFIELD RD TCU NOBLESVILLE, IN 46060				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	ID EFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Supervisor then state an F.S.E.S. for this	ted that they (the facility) had deficient practice, and that it with their plan of correction.			the potential to be affected be the same deficient practice we be identified and what corrective action will be take	vill	
	3.1-19(b)				·All patients located on the 4 floor have the potential to be affected by this alleged practic		
					What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur	nto	
					F.S.E.S. audit will be complete when structural changes are r to the Unit		
					How the corrective action(s) we monitored to ensure the defici practice will not recur, i.e., who quality assurance program will put into place	ent at	
					The Hospital will update the F.S.E.S. survey/audit when ar life safety structural changes a made to this area or annually demonstrate equivalent compliance.	are	
					What date the systemic changes will be completed:		
					With acceptance of the F.S.E. survey/audit, systemic correct will be completed by July 6, 20	ions	

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~	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155669	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/18/2019	
NAME OF PROVIDER OR SUPPLIER RIVERVIEW TCU				STREET ADDRESS, CITY, STATE, ZIP COD 395 WESTFIELD RD TCU NOBLESVILLE, IN 46060			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
					CROSS-REFERENCED TO THE APPROP		

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