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

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3)			SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING			COMPLETED	
	155669		B. W	B. WING			2018	
				CTREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER				ESTFIELD RD TCU			
RIVERVI	EW TOLL				SVILLE, IN 46060			
KIVEKVII	EWICO			NOBLE	3VILLE, IN 40000			
(X4) ID	SUMMARY S	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	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
E 0000								
Bldg								
	An Emergency Prep	paredness Survey was	E 00	000	Preparation and /or execution	of		
	conducted by the In	diana State Department of			this plan of correction in gener			
	-	ee with 42 CFR 483.73.			or this corrective action in	,		
					particular, does not constitute	an		
	Survey Date: 08/20)/18			admission of agreement by thi			
	_				facility of the facts alleged or			
	Facility Number: 0	11046			conclusions set forth in this			
	Provider Number:				statement of deficiencies. The			
	AIM Number: NA				plan of correction and specific			
					corrective actions are prepared			
	At this Emergency 1	Preparedness survey,			and /or executed in compliance			
		s found in substantial			with state and federal laws.			
		nergency Preparedness						
		ledicare and Medicaid			The plan of correction constitu	tes		
		lers and Suppliers, 42 CFR			our Credible Allegation of			
	483.73	Tr			compliance with all regulatory			
					requirements.			
	The facility has 25 of	certified beds. At the time of						
	the survey, the cens				This provider requests A Desk			
	, , , , , , , , , , , , , , , , , , ,				Review in lieu of a Post Surve			
	Ouality Review con	npleted on 08/27/18 - DA			revisit. (See the attached	,		
	Ç,	r			documentation to support a de	sk		
					review) Our Date of compliance			
					is:			
					1			
					9/10/2018			
					3.13/2010			
E 0035							'	
SS=C								
Bldg								
	Based on record rev	view and interview, the facility	E 00	035	E 035		09/10/2018	
		emergency preparedness					57/10/2010	
		n includes a method for sharing			It is the practice of this provide	r to		
	-	e emergency plan that the			abide by Emergency			
		ned is appropriate with			Preparedness communication	plan		
	-	amilies or representatives in			that complies with Federal, Sta	-		
		CFR 483.73(c)(8). This			and local laws.	-		

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

TITLE

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

PRINTED: 09/06/2018 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155669		UILDING		COMPL 08/20/	ETED	
NAME (OF PROVIDER OR SUPPLIE	₹		ADDRESS, CITY, STATE, ZIP COD ESTFIELD RD TCU		
RIVEF	RVIEW TCU			ESVILLE, IN 46060		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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
	Based on record rewith the Director of ensure the emergent communication plate information from the facility has determined the facility Administration in the could not verify the interview at the time of T.C.U. acknowled preparedness communication appropriate with representatives. Dure 08/20/18 at 2:05 p.1 the Engineering Sure Engineer, no additi	ould affect all occupants. view on 08/20/18 at 11:06 a.m., f T.C.U., the facility failed to		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Attached is the policy for the method to share information regarding the emergency plant patients and their families or representatives. The letter that be provided is also attached. Information will be included in Admission packet for all future patients and will be given to all current patients. How will other patients having the potential to be affected be the same deficient practice where identified and what corrective action will be taken. All patients located on the affected by this alleged practice. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur. The Administrator/designee who complete audits on new admissions dailing 90 days then weekly for 90 days then monthly thereafter for total 2 months. To insure that	n e to t will Fhis the il ng y vill n th th te it y for ys	

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

PRINTED: 09/06/2018 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155669	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/20/2018
NAME OF F	PROVIDER OR SUPPLIEF		395 W	ADDRESS, CITY, STATE, ZIP COD ESTFIELD RD TCU ESVILLE, IN 46060	
(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)	(X5) COMPLETION DATE
				patients, families and representatives are being not of emergency plan for the TC	
				How the corrective action(s) we monitored to ensure the defic practice will not recur, i.e., who quality assurance program will put into place	ient nat
				Results of audit findings will be reported to the QA committee monthly for 12 months If 100 compliance is not maintained action plan will be developed. 12 months compliance the QA	e 0% an . After
				committee will determine the frequency of continued monitor	
				What date the systemic changes will be completed:	
				Systemic corrections will be completed by September 10, 2018.	
K 0000					
Bldg. 02	Licensure Survey w	11046	K 0000	Preparation and /or execution this plan of correction in gene or this corrective action in particular, does not constitute admission of agreement by the facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific	eral, e an nis
	AIM Number: NA			corrective actions are prepare	

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09/06/2018 PRINTED: DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES 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 02 155669 B. WING 08/20/2018 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 395 WESTFIELD RD TCU RIVERVIEW TCU NOBLESVILLE, IN 46060 (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 and /or executed in compliance At this Life Safety Code survey, Riverview TCU with state and federal laws. was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR The plan of correction constitutes Subpart 483.90(a), Life Safety from Fire and the our Credible Allegation of 2012 edition of the National Fire Protection compliance with all regulatory Association (NFPA) 101, Life Safety Code (LSC), requirements. Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2 This provider requests A Desk Review in lieu of a Post Survey This facility is located on the fourth floor of a fully revisit. (See the attached sprinklered five story building. This facility was documentation to support a desk determined to be of Type I (332) construction. The review) Our Date of compliance 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 9/10/2018 smoke detectors installed in all 13 resident sleeping rooms. The facility has a capacity of 25 and had a census of 10 at the time of this visit. All areas where residents have customary access

K 0225 SS=F Bldg. 02

NFPA 101

services were sprinklered.

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

were sprinklered and all areas providing facility

Quality Review completed on 08/27/18 - DA

K 0225

K 225

It is the practice of this provider to abide by the Life Safety Code determined appropriate for this Unit.

09/10/2018

What corrective action(s) will

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155669		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 08/20/2018	
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 395 WESTFIELD RD TCU NOBLESVILLE, IN 46060			
(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	
	be without openings the smoke proof end outside yard, court, passageway shall be of the building by a rating. This deficier staff and visitors. Findings include: Based on observation with the Director of Supervisor, the four located is divided in and has three stairw resistance rating of the first floor of the door is less than two the time of the obse T.C.U. and the Eng acknowledged each passageways are no remainder of the buresistance rating. The stated that they (the	e LSC IDENTIFYING INFORMATION so other than the entrance from closure and the door to the or public way. The exit is separated from the remainder two hour fire resistance at practice affects all residents, ons on 08/20/18 at 12:50 p.m. T.C.U. and the Engineering th floor on which the TCU is not two smoke compartments rell exits. Additionally, the fire the three exit enclosures on hospital to the exit discharge to hours. Based on interview at rivations, the Director of ineering Supervisor of the three exit discharge t separated from the ilding by a two hour fire the Engineering Supervisor facility) had an F.S.E.S. for ce, and that it would be		be accomplished for those residents found to have bee affected by the deficient practice? This provider completed an assessment by Fire Safety Evaluation System (FSES to demonstrate equivalent compliance. (See attached FS survey) How will other patients having the potential to be affected to the same deficient practice to be identified and what corrective action will be taken. All patients located on the affected by this alleged practice. What measures will be put in 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 into the Unit. How the corrective action(s) when monitored to ensure the deficient practice will not recur, i.e., who quality assurance program will put into place.	n DATE n SES ng Dy will en 4th ce. nto made vill be ient at	
				The Hospital will update the		

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 02 COMPLETED			ETED		
		155669	B. WI	NG		08/20/	2018
NAME OF P	ROVIDER OR SUPPLIER			395 WE	DDRESS, CITY, STATE, ZIP COD STFIELD RD TCU SVILLE, IN 46060		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(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 APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0252 SS=F Bldg. 02	NFPA 101 Number of Exits - Number of Exits - Every corridor sha less than two appr with Sections 7.4 a through any interv other than corridor 18.2.5.4, 19.2.5.4 Based on observation failed to ensure 2 of provided with at lea continuous path of the	Corridors Corridors Ill provide access to not roved exits in accordance and 7.5 without passing ening rooms or spaces	K 02		FSES survey/audit when any list 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 FSES survey/audit, systemic corrective will be completed by September 10, 2018 K 252 It is the practice of this provide abide by the Life Safety Code determined appropriate for this Unit.	o ons er	09/10/2018
	with the Director of	ons on 08/20/18 at 12:52 p.m. T.C.U. and the Engineering J has two emergency exits.			What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?		
	smoke compartment compartment has tw exit is an exit stairw	ntal exit into the adjacent t. The adjacent smoke to exit stairwells. The second well which does not connect to rectly to the exterior. Based on			·This provider completed an assessment by Fire Safety Evaluation System (FSES to demonstrate equivalent		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155669	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 08/20/2018
NAME OF P	PROVIDER OR SUPPLIEF	₹	395 W	ADDRESS, CITY, STATE, ZIP COD ESTFIELD RD TCU ESVILLE, IN 46060	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY 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)	(X5) COMPLETION DATE
	Director of T.C.U. acknowledged each	e of the observations, the and the Engineering Supervisor I smoke compartment is not		compliance. (See attached FS survey)	
	to the exterior of th Supervisor then sta an F.S.E.S. for this	ast one exit discharging directly e building. The Engineering ted that they (the facility) had deficient practice, and that it I with their plan of correction.		How will other patients havin the potential to be affected be the same deficient practice whe identified and what corrective action will be take	y 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	ito
				FSES audit will be completed when structural changes are n to the Unit	nade
				How the corrective action(s) we monitored to ensure the deficient practice will not recur, i.e., who quality assurance program will put into place	ent at
				The Hospital will update the Fi survey/audit when any life safe structural changes are made to this area or annually to demonstrate equivalent compliance.	ety
				What date the systemic changes will be completed:	

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROV		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICA		IDENTIFICATION NUMBER	A. BU	JILDING	<u>02</u> COMPI		
	155669 B. WING		TING 08/20/2018			/2018	
NAME OF PROVIDER OR SUPPLIER RIVERVIEW TCU			395 WE	ADDRESS, CITY, STATE, ZIP COD ESTFIELD RD TCU SVILLE, IN 46060			
(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
K 0712 SS=C Bldg. 02	NFPA 101 Fire Drills Fire Drills				With acceptance of the FSES survey/audit, systemic correcti will be completed by Septemb 10, 2018		
Bidg. 02	Fire drills include to alarm signal and so conditions. Fire drand unexpected ticonditions, at leas The staff is familial aware that drills are routine. Where draws 9:00 PM and 6:00 announcement manualible alarms. 19.7.1.4 through 11) Based on record facility failed to ensure the verification of the signal to the monitor the last 4 quarters. It in health care occuptransmission of a fire of emergency fire conditions.	ay be used instead of	K 0°	712	K 712 It is the practice of this provide abide by the requirement for quarterly fire drills and to insur that a drill is conducted quarte on each shift and that these drivill include verification of transmission of the fire alarm signal to the monitoring station	re rly rills	09/10/2018
	"Fourth Floor North Drill" on 08/20/18 a had no documented				What corrective action(s) wil be accomplished for those residents found to have beer affected by the deficient practice?		
		fire alarm signal with the coring company. Based on			Per the statement from ISD	Н	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	02	COMPLETED		
		155669	B. W	ING		08/20/	2018	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	8			ESTFIELD RD TCU			
RIVERV	IEW TCU				SVILLE, IN 46060			
	1				1			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE	
		e of record review, the Director			verification of transmission of			
		the fire drills kept by the			fire alarm signal to the monitor	-		
		ment may have that			station was not available. Dur	_		
		ented on them. Those drills			the survey this information wa			
		also did not document a			provided to the surveyor from			
		ransmission of the fire alarm			Hospital wide drill documentat			
		lity alarm monitoring company.			At that time the surveyor said			
	_	ference on 08/20/18 at 2:05 p.m.			this information was adequate			
		f T.C.U., the Engineering			(See attached documentation	-		
	_	acility Engineer, no additional ence could be provided			·Copies of the TCU specific			
		*			drills have been made to assis			
	contrary to this defi	icient finding.			surveyor in locating the TCU in			
	2.1.10(b)				hospital wide drill. Since comp	nete		
	3.1-19(b)				documentation is include in			
	3.1-51(c)				Hospital wide packet this is when the second drill drill			
	2) Pasad on record	review and interview, the			documentation of the TCU dril			
	1 '	nduct quarterly fire drills for 1			will be maintained in the future	÷ 10		
	1	19.7.1.6 requires drills to be			prevent any confusion.			
	_	on each shift under varied			Schedule of fire drills will be			
		ficient practice affects all staff			established monthly and revie by Quality Assurance team	weu		
	and residents.	neight practice affects an staff			monthly to insure timeliness o	f		
	and residents.				drills.	ı		
	Findings include:				dillis.			
	i mamga merade.				How will other patients havir	na		
	Based on record rev	view of the documents entitled			the potential to be affected b	-		
		h - Transitional Care Unit Fire			the same deficient practice v	-		
		at 10:08 a.m. with the Director of			be identified and what			
		o documentation for a third			corrective action will be take	n		
		e fourth quarter (October,						
		ember) of 2017. Based on			·All patients located on the 4	lth .		
		e of record review, the Director			floor have the potential to be			
		edged that a fourth quarter fire			affected by this alleged practic	ce.		
		e T.C.U. unit could not be						
	located for review.	During the exit conference on			What measures will be put in	ito		
		m. with the Director of T.C.U.,			place or what systemic			
		pervisor, and a facility			changes you will make to			
		onal information or evidence			ensure that the deficient			
		contrary to this deficient			practice does not recur			
	finding.	•						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOI	R MEDICARE & MEDIC				OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155669	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 08/20/2018
	PROVIDER OR SUPPLIER	3	395 W	ADDRESS, CITY, STATE, ZIP COD ESTFIELD RD TCU ESVILLE IN 46060	
NAME OF I RIVERVI (X4) ID PREFIX TAG	EW TCU SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	395 W		ee ad each eept en of ee. eill be ent eat I be erills e will or eat
				each month to include a drill of each shift once per quarter. If are not 100% compliant an additional action plan will be p place.	drills

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·Safety committee will review each fire drill to be sure all

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~	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155669	Ì	ILDING	onstruction 02	(X3) DATE COMPL 08/20 /	ETED
NAME OF P	ROVIDER OR SUPPLIER			395 WE	ADDRESS, CITY, STATE, ZIP COD ESTFIELD RD TCU SVILLE, IN 46060		
(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 APPROPRIAT DEFICIENCY)	TE	(X5) COMPLETION DATE
					documentation is compliant an drills are held timely.	ıd	
					What date the systemic changes will be completed: ·With acceptance of this acti	on	
					plan all measures will be completed by September 10, 2		

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