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	08/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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: 08/20/18 Facility Number: 011046 Provider Number: 155669 AIM Number: NA At this Emergency Preparedness survey, Riverview TCU was found in substantial 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 10. Quality Review completed on 08/27/18 - DA	E 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: 9/10/2018	
E 0035 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives in accordance with 42 CFR 483.73(c)(8). This	E 0035	E 035 It is the practice of this provider to abide by Emergency Preparedness communication plan that complies with Federal, State and local laws.	09/10/2018

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

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	deficient practice could affect all occupants. Findings include: Based on record review on 08/20/18 at 11:06 a.m., with the Director of T.C.U., the facility failed to ensure the emergency preparedness communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives. The facility Administrator stated he thought "that information is given to families by the Admissions staff verbally at the time of registration." But he could not verify that information. Based on further interview at the time of record review, the Director of T.C.U. acknowledged that the emergency preparedness communication plan failed to include a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives. During the exit conference on 08/20/18 at 2:05 p.m. with the Director of T.C.U., the Engineering Supervisor, and a facility Engineer, no additional information or evidence could be provided contrary to this deficient finding.		**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 plan to patients and their families or representatives. The letter that will be provided is also attached. This information will be included in the Admission packet for all future patients and will be given to all current patients. **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** The Administrator/designee will complete audits on new admissions daily for 90 days then weekly for 90 days then monthly thereafter for total of 12 months. To insure that	

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			patients, families and representatives are being notified of emergency plan for the TCU. 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 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 September 10, 2018.	
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 483.90(a). Survey Date: 08/20/18 Facility Number: 011046 Provider Number: 155669 AIM Number: NA	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	

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	At this Life Safety Code survey, Riverview TCU 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 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 10 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 08/27/18 - DA		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: 9/10/2018	
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 yard or court having direct access to a public way, or into an exit passageway. Such exit passageways shall	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**	09/10/2018

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	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 on 08/20/18 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)		**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 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	

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			FSES 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 FSES survey/audit, systemic corrections will be completed by September 10, 2018	
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 on 08/20/18 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	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	09/10/2018

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	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 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)		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 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 or annually to demonstrate equivalent compliance. **What date the systemic changes will be completed:**	

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			With acceptance of the FSES survey/audit, systemic corrections will be completed by September 10, 2018	
K 0712 SS=C Bldg. 02	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 1) Based on record review and interview, the facility failed to ensure 12 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills for 4 the last 4 quarters. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all patients in the unit, as well as staff and visitors. Findings include: Based on record review of the documents entitled "Fourth Floor North - Transitional Care Unit Fire Drill" on 08/20/18 at 9:50 a.m., the fire drill forms had no documented verification of the transmission of the fire alarm signal with the facility alarm monitoring company. Based on	K 0712	K 712 It is the practice of this provider to abide by the requirement for quarterly fire drills and to insure that a drill is conducted quarterly on each shift and that these drills will include verification of transmission of the fire alarm signal to the monitoring station. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Per the statement from ISDH surveyor documentation of	09/10/2018

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	interview at the time of record review, the Director of T.C.U. indicated the fire drills kept by the Engineering department may have that information documented on them. Those drills were reviewed and also did not document a verification of the transmission of the fire alarm signal with the facility alarm monitoring company. During the exit conference on 08/20/18 at 2:05 p.m. with the Director of T.C.U., the Engineering Supervisor, and a facility Engineer, no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b) 3.1-51(c) 2) Based on record review and interview, the facility failed to conduct quarterly fire drills for 1 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review of the documents entitled "Fourth Floor North - Transitional Care Unit Fire Drill" on 08/20/18 at 10:08 a.m. with the Director of T.C.U., there was no documentation for a third shift fire drill in the fourth quarter (October, November and December) of 2017. Based on interview at the time of record review, the Director of T.C.U. acknowledged that a fourth quarter fire drill for 2017 on the T.C.U. unit could not be located for review. During the exit conference on 08/20/18 at 2:05 p.m. with the Director of T.C.U., the Engineering Supervisor, and a facility Engineer, no additional information or evidence could be provided contrary to this deficient finding.		verification of transmission of the fire alarm signal to the monitoring station was not available. During the survey this information was provided to the surveyor from the Hospital wide drill documentation. At that time the surveyor said that this information was adequate. (See attached documentation) ·Copies of the TCU specific fire drills have been made to assist surveyor in locating the TCU in hospital wide drill. Since complete documentation is include in Hospital wide packet this is where documentation of the TCU drills will be maintained in the future to prevent any confusion. ·Schedule of fire drills will be established monthly and reviewed by Quality Assurance team monthly to insure timeliness of drills. **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**	

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	3.1-19(b) 3.1-51(c)		·Schedule for fire drills will be made in advance and reviewed monthly by Quality Assurance team to insure that a drill is provided timely on each shift each quarter. ·All documentation will be kept together in Engineering department to prevent any questions regarding verification of transmission for the fire alarm signal to the monitoring station. This documentation will be audited monthly for compliance. 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 ·All documentation for fire drills will be kept in Engineering Department to insure that all information is reviewed during surveys. ·The Administrator/designee will complete audits each month for total of 12 months to insure that fire drills are held and conducted each month to include a drill on each shift once per quarter. If drills are not 100% compliant an additional action plan will be put in place. ·Safety committee will review each fire drill to be sure all	

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			documentation is compliant and drills are held timely. **What date the systemic changes will be completed:** ·With acceptance of this action plan all measures will be completed by September 10, 2018	