

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155690	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/17/2015
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NAME OF PROVIDER OR SUPPLIER MEADOW BROOK REHABILITATION CENTRE & SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 1821 LINDBERG RD ANDERSON, IN 46012
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 02/17/15</p> <p>Facility Number: 000027 Provider Number: 155690 AIM Number: 100266180</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Meadow Brook Rehabilitation Centre and Suites was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in</p>	K010000	Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.	

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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K010130 SS=E	<p>resident rooms. The facility has a capacity of 97 and had a census of 44 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas which provide facility services were sprinklered except for one detached garage used for facility storage which was not sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 02/20/15.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation, interview and review the facility failed to ensure the care and maintenance of 2 of 2 rolling fire doors were in accordance with NFPA 80. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A</p>	K010130	<p>K-130</p> <p>1.No residents were affected by the deficient practice. The Kitchen rolling fire doors were inspected by OverheadDoor Company on 2/26/15. Both doors passed inspection</p> <p>2.All residents had the potential to be affected by the deficient practice. The Kitchen rolling fire doors were inspected by Overhead Door Company on 2/26/15. Both doors passed inspection</p> <p>3.The Kitchen rolling fire doors were inspected by Overhead Door</p>	02/26/2015

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	<p>written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect any resident using the center corridor which is adjacent to the Kitchen to exit in an emergency as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observations on 02/17/15 at 1:38 p.m. with the Maintenance Supervisor, there were two metal rolling fire doors protecting openings in the kitchen from the center hall exit pathway. The metal rolling fire doors lacked attached inspection tags indicating when the last annual inspection was done. Based on interview on 02/17/15 at 3:37 p.m. with the Maintenance Supervisor and concurrent review of Fire Inspection records there was no additional documentation of an annual inspection or test to check for proper operation and full closure.</p> <p>3.1-19(b)</p>		<p>Company on 2/26/15. Both doors passed inspection. Overhead Door has scheduled the facility for an annual inspection of the Kitchen rolling fire doors, and the Maintenance Director has added this inspection to his list of annual inspections.</p> <p>4. This preventative maintenance annual inspection will be reviewed in the facilities Quality Assurance meeting for continued compliance and will be ongoing.</p> <p>5. Date Corrected: 2/26/15</p>				