

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155358	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/28/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  MEADOWS MANOR CONVALESCENT & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 POPLAR ST TERRE HAUTE, IN 47803
-------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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
K0000	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 09/27/12 and 09/28/12</p> <p>Facility Number: 000249 Provider Number: 155358 AIM Number: 100267640</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Meadows Manor Convalescent &amp; Rehab Center 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>	K0000	<p>Please consider this Plan of Correction as our allegation of compliance. Disclaimer: Meadows Manor Convalescent and Rehab Center does not believe and does not admit that any deficiencies existed before, during or after the survey. Meadows Manor Convalescent and Rehab Center reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and Meadows Manor Convalescent and Rehab Center reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self critical examination privileges which Meadows Manor Convalescent and Rehab Center does not waive, and reserves the right to assert in any administrative civil or criminal claim, action or proceeding. Meadows Manor Convalescent and Rehab Center offers its responses, credible allegations of compliance and plan of correction as part of its</p>	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155358	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  09/28/2012
NAME OF PROVIDER OR SUPPLIER  MEADOWS MANOR CONVALESCENT & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3300 POPLAR ST TERRE HAUTE, IN 47803		
(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	
	<p>This one story facility with a basement was determined to be of Type II (000) construction and was fully sprinklered with the exception noted in K-56. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. Battery powered smoke detectors are provided in all resident rooms. The facility has the capacity for 89 and had a census of 68 at the time of this survey.</p> <p>The facility was found not in compliance with state law in regard to sprinkler coverage and in compliance with state law in regard to smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered with the exceptions noted in K-56. All areas providing facility services were sprinklered, except a detached shed used for facility equipment storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/03/12.</p> <p>The facility was found not in</p>		ongoing effort to provide quality care to its residents.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155358	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/28/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  MEADOWS MANOR CONVALESCENT & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 POPLAR ST TERRE HAUTE, IN 47803
-------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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
	compliance with the aforementioned requirements as evidenced by:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155358	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/28/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  MEADOWS MANOR CONVALESCENT & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 POPLAR ST TERRE HAUTE, IN 47803
-------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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
K0029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 8 doors to a hazardous area such as a kitchen would self close. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors which close automatically upon activation of the fire alarm system.</p> <p>Furthermore, doors to hazardous areas are required to latch in the door frame when closed to keep the door tightly closed. This deficient practice affects visitors, staff, and 10 or more residents in the adjacent Zone 2 corridor.</p> <p>Findings include:</p> <p>Based on observation with the</p>	K0029	<p>The door closer was adjusted on the north kitchen door so that it closes and latches properly. This item could potentially affect all residents as well as visitors and staff, as do all areas of fire safety.</p> <p>The facility maintenance supervisor will be the responsible person and will monitor by visibly inspecting the facility doors to ensure that this type of finding does not recur.</p>	10/24/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155358	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/28/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  MEADOWS MANOR CONVALESCENT & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 POPLAR ST TERRE HAUTE, IN 47803
-------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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
	<p>maintenance director on 09/28/12 at 3:25 p.m., the self closing north door separating the kitchen from the Zone 2 exit corridor failed to close upon activation of the fire alarm system. The maintenance director agreed at the time of observation, the door should have closed and latched.</p> <p>3.1-19(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155358	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/28/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  MEADOWS MANOR CONVALESCENT & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 POPLAR ST TERRE HAUTE, IN 47803
-------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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
K0056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to provide complete sprinkler coverage for 1 of 7 first floor smoke compartments in a one story building of Type V (000) construction. LSC 19.1.6.2 requires one story facilities of Type V (000) construction be provided with complete sprinkler protection. This deficient practice could affect visitors, staff and 10 or more residents in Zone 2.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 09/27/12 at 1:10 p.m., sprinkler protection was not provided for</p>	K0056	<p>Fire sprinkler protection was installed on 10/9/2012 to the area between the central shower and corridor. This item could potentially affect all residents as well as visitors and staff, as do all areas of fire safety. The facility maintenance supervisor will be the responsible person and will monitor by visibly inspecting the facility to ensure that this type of finding does not recur.</p>	10/24/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155358	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/28/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  MEADOWS MANOR CONVALESCENT & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 POPLAR ST TERRE HAUTE, IN 47803
-------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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
	<p>the four by five foot entry access between the central shower and corridor. The maintenance director acknowledged at the time of observation, the area was not protected by the corridor sprinklers in the area.</p> <p>3.1-19(b) 3.1-19(ff)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155358	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/28/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  MEADOWS MANOR CONVALESCENT & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 POPLAR ST TERRE HAUTE, IN 47803
-------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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
K0076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 10 cylinders of nonflammable gases in the oxygen supply storage room was properly stored; chained or supported in a cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraints shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect visitors, staff and 10 or more residents in the adjacent Zone 2 corridor.</p> <p>Findings include:</p>	K0076	<p>An oxygen cylinder rack was installed in the oxygen room for proper storage of the cylinders. This item could potentially affect all residents as well as visitors and staff, as do all areas of fire safety. The facility maintenance supervisor will be the responsible person and will monitor by visibly inspecting the oxygen room for proper cylinder storage to ensure that this type of finding does not recur.</p>	10/24/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155358	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/28/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  MEADOWS MANOR CONVALESCENT & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 POPLAR ST TERRE HAUTE, IN 47803
-------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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
	<p>Based on observation with the maintenance director on 09/28/12 at 3:10 p.m., one oxygen cylinder was stored in the oxygen supply storage room on top of nine oxygen cylinders in a rack. The cylinder rested at an angle on top of and between the valves of the cylinders upon which it rested. The maintenance director said at the time of observation, the cylinder should not have been stored this way.</p> <p>3.1-19(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155358	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/28/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  MEADOWS MANOR CONVALESCENT & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 POPLAR ST TERRE HAUTE, IN 47803
-------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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
K0144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate</p>	K0144	The generator will be exercised under load for 30 minutes per month in accordance with NFPA 99. This item could potentially affect all Residents as well as visitors and staff, as do all areas of fire safety. The facility maintenance supervisor will be the responsible person and will monitor by visibly inspecting the "generator test" chart to ensure that this type of finding does not recur	10/24/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155358	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  09/28/2012
NAME OF PROVIDER OR SUPPLIER  MEADOWS MANOR CONVALESCENT & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3300 POPLAR ST TERRE HAUTE, IN 47803		
(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	
	<p>rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on interview and review of the emergency Generator Test with the maintenance director and maintenance man # 1 on 09/28/12 at 1:40 p.m., documentation of a monthly emergency generator load test since 07/12/12 was not found. The maintenance director said at the time of record review, his staff were required to do the monthly load tests and document them. Maintenance man # 1, who provided the incomplete generator testing records at the time of review, said the load tests were done but not documented.</p> <p>3.1-19(b)</p>				

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

PRINTED: 10/31/2012

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155358	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/28/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  MEADOWS MANOR CONVALESCENT & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 POPLAR ST TERRE HAUTE, IN 47803
-------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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