

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155428	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2012
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NAME OF PROVIDER OR SUPPLIER MERIDIAN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2102 S MERIDIAN ST INDIANAPOLIS, IN 46225
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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
K0000	<p>A Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health.</p> <p>Survey Date: 08/21/12</p> <p>Facility Number: 000386 Provider Number: 155428 AIM Number: 100286820</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Quality Assurance Walk-thru survey, Meridian Nursing and Rehabilitation Center was found not in compliance with 410 IAC 16.2-3.1-19(ff).</p> <p>This one story facility was determined to be of Type II (111) construction and was fully sprinklered. 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 in all resident sleeping rooms. The facility has a capacity of 44 and had a census of 37 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage. The facility was found not in compliance</p>	K0000		

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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	<p>with the state law in regard to smoke detector coverage.</p> <p>All areas where residents have customary access were sprinklered. The facility has two detached buildings, wooden storage sheds, providing facility services which were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/23/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K9999	<p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(a) The facility must be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel, and the public.</p> <p>This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to maintain a preventive maintenance program for battery operated smoke detectors installed in 20 of 20 resident sleeping rooms. This deficient practice could affect 37 residents in the facility.</p> <p>Findings include:</p> <p>Based on observations with the Plant Operations Supervisor during a tour of the facility from 12:50 p.m. to 2:10 p.m. on 08/21/12, battery operated smoke detectors were installed in 20 of 20 resident sleeping rooms. Based on interview at the time of observation, the Plant Operations Supervisor stated documentation of periodic testing and cleaning of battery operated smoke</p>	K9999	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>K 9999 – Smoke Detectors</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</p> <p>A smoke detector standard and guidelines policy and preventive maintenance audit sheet have been implemented and put into place to check monthly battery operated smoke detectors in resident rooms 1 thru 20 and any other battery operated smoke detectors to meet the state and National Fire Protection Association (NFPA) code.</p> <p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</p>	09/20/2012			

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	<p>detectors in resident sleeping rooms was not available for review. The Plant Operations Supervisor stated the battery operated smoke detectors were installed in each resident sleeping room in June 2012 and acknowledged a preventive maintenance program for battery operated smoke detectors has not been implemented.</p> <p>3.1-19(a)</p>		<p>A facility wide audit was completed to ensure that all smoke detectors were tested and the batteries were checked. The verification record was completed. No other issues were identified.</p> <p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</p> <p>The Maintenance Director has been in-serviced as to the required components of this tag.</p> <p>The Facility Preventative Maintenance Checklist was modified to include the verification and compliance to this standard. Any adjustments identified will be addressed immediately.</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>The monitoring of this tag will be a joint effort between the NHA and the Maintenance Director as they will make weekly walking rounds for the next four weeks and bi-monthly for 6 months and ensure the testing and battery check of the smoke detectors is done. A report of their findings will be discussed at the monthly Risk Management/QA meeting to determine when compliance has been met and quarterly monitoring by</p>	

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			<p>the Assistant Director of Plant Operations/Designee is recommended.</p> <p>(e) Date of compliance: 9/20/2012</p>	