

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 02/12/2015
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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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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: 02/12/15</p> <p>Facility Number: 000386 Provider Number: 155428 AIM Number: 100286820</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Meridian Nursing and Rehabilitation 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> <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 corridor and in all areas open to the corridor. The facility has battery</p>	K010000		
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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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K010046 SS=F	<p>operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 44 and had a census of 40 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for two detached buildings constructed of wood which were each not sprinklered.</p> <p>The facility has elected to utilize a Categorical Waiver pertaining to clean waste recycling containers.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 02/16/15.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on record review, observation and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 3 of 3 battery powered lights for the most recent</p>	K010046	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.	03/14/2015

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	<p>12 month period. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals for not less than 30 seconds and an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ -hr duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Environmental Director from 9:40 a.m. to 11:40 a.m. on 02/12/15, documentation of annual testing for not less than 1 ½ -hr duration for facility battery powered emergency lights for the most recent twelve month period was not available for review. The entry for annual 90 minute testing in "Weekly Generator System Service & Testing" documentation was left blank for the most recent twelve month period. In addition, the duration of monthly functional testing for battery powered emergency lights itemized by location was not available for review.</p>		<p>K046 Emergency lighting atleast 1 ½ hour duration is provided</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</p> <p>All 3 battery back-up lights were identified, tested for monthly 30 second and annually for 90 minutes and logged on an audit sheet. There were no concerns.</p> <p>1. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</p> <p>Any resident, visitor, vendor or staff member has the potential to be affected, but none were identified.</p> <p>2. What measures will be put into place or what systematic changes you will make to ensure that the practice does not reoccur:</p> <p>Maintenance director in-service on ensuring all back-up lights are tested for 30 seconds monthly and 90 seconds annually and documentation of said tests are available for review</p> <p>3. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will</p>	

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	<p>"Emergency Exit Lighting" documentation for February 2014 through January 2015 did not state the duration of monthly functional testing. "Weekly Generator System Service & Testing" documentation stated facility battery operated lights were functional tested for thirty seconds for the most recent twelve month period but did not state which lights were tested. Based on observation with the Administrator during a tour of the facility from 9:15 a.m. to 9:40 a.m. and with the Environmental Director from 11:40 a.m. to 12:15 p.m. on 02/12/15, a total of three battery powered emergency lights, including one at the emergency generator location, were noted and each battery powered light operated when its respective test button was depressed. Based on interview at the time of record review, the Environmental Director acknowledged documentation of annual testing for not less than 1 ½ -hr duration for facility battery powered emergency lights for the most recent twelve month period was not available for review and an itemized listing by location and duration of monthly functional testing was not available for review.</p> <p>3.1-19(b)</p>		<p>be put into place:</p> <p>A monthly audit will be conducted on battery backup lights times 6 months or until compliance is reached. Results will be discussed in monthly QA meeting.</p> <p>4. Date of compliance 3-14-15</p>				

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K010056 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 ensure the sprinkler system was installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 6-2.3.4 states the cumulative horizontal length of an unsupported arm over to a sprinkler, sprinkler drop, or sprig-up shall not exceed 24 inches for steel pipe or 12 inches for copper tube. This deficient practice could affect 16 residents, staff and visitors in the vicinity of Rest Room 4.</p> <p>Findings include: Based on observation with the Environmental Director during a tour of</p>	K010056	<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>K056 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: A support hanger was added to the steel sprinkler pipe that exceeded 36 inches in restroom 4.</p> <p>1. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</p>	03/14/2015
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	<p>the facility from 11:40 a.m. to 12:15 p.m. on 02/12/15, a 36 inch horizontal length of steel sprinkler pipe installed in Rest Room 4 was an unsupported armover to a sprinkler. Based on interview at the time of observation, the Environmental Director acknowledged the aforementioned sprinkler location was an unsupported armover greater than 24 inches in length for a steel pipe.</p> <p>3.1-19(b) 3.1-19(ff)</p>		<p>A facility wide audit was conducted by the vender (Safe Care) and the environmental director to look for any sprinkler lines that exceed 36 inches and need any additional hangers. None were identified.</p> <p>2. What measures will be put into place or what systematic changes you will make to ensure that the practice does not reoccur: The maintenance director was in-serviced on ensuring hangers were in place for any sprinkler line exceeding 36 inches.</p> <p>3. 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: A monthly audit will be conducted to ensure all current hangers are in place on sprinkler lines exceeding 36 inches.</p> <p>4. Date of compliance 3-14-15</p>		