

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155143	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 12/13/2013
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NAME OF PROVIDER OR SUPPLIER MEADOWS MANOR NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 3150 N SEVENTH ST TERRE HAUTE, IN 47804
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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>This Survey was conducted in conjunction with a Life Safety Code and Environmental Preoccupancy Survey for a dining room expansion.</p> <p>Survey Date: 12/13/13</p> <p>Facility Number: 000067 Provider Number: 155143 AIM Number: 100267880</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Meadows Manor North 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</p>	K010000	<p>Please consider this Plan of Correction as our allegation of compliance. Disclaimer: Meadows Manor North Retirement does not believe and does not admit that any deficiencies existed before, during or after survey. Meadows reserve all rights to contest proceeding 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 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 potential applicable peer review, quality assurance or self critical examination privileges which Meadows does not waive and reserves the right to assert in any administrative civil or criminal claim, action or proceeding. Meadows offers its response, credible allegation of compliance and plan of correction as part of its ongoing effort to provide quality of care.</p>	
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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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	<p>fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, in resident rooms and in spaces open to the corridors. The facility has the capacity of 104 and had a census of 76 at the time of this survey.</p> <p>All areas accessible to residents and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/23/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure doors protecting corridor openings in 1 of 7 smoke compartments could automatically latch into the door frame. This deficient practice affects staff, visitors and 10 or more residents in dining room smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Buildings Manager on 12/13/13 at 1:45 p.m., the double doors separating the dining room from the exit corridor had no latches to keep the doors closed tightly in their door frame. The Buildings Manager acknowledged at the time of observation, the doors could not latch into the door</p>	K010018	Latching devices will be installed on the double doors that separate the dining room from the exit corridor. They will latch to keep the doors closed tightly in their door frame to resist the passage of smoke. See attached paper showing door hardware. This item could potentially affect all residents in the facility, as so all areas of fire safety. The maintenance Director will be responsible person and will monitor by visibly inspecting all maintenance and construction to ensure that this type of finding does not recur.	01/12/2014			

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	frame. 3.1-19(b)			
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K010021 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 doors to the kitchen, a hazardous area, were held open only by devices which would allow the doors to close upon activation of the fire alarm system. This deficient practice affects visitors, staff and 10 or more residents in the dining room.</p> <p>Findings include:</p> <p>Based on observation with the Buildings Manager on 12/13/13 at 1:40 p.m., the door separating the dining room and kitchen dish room which is open to the main kitchen was equipped with a kick down door stop. The Buildings Manager acknowledged the door would not automatically close when the fire alarm was activated.</p>	K010021	The kick down door stop will be removed and an automatic door holder will installed that will close automatically upon activation of the fire alarm system. This item could potentially affect all residents in the facility, as do all areas of fire safety. The Maintenance Director will be the responsible and will monitor by visibly inspecting all maintenance and construction to ensure that this type of finding does not recur.	01/12/2014			

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K010029 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 2 of 2 doors to the kitchen, a hazardous area, could self close automatically or upon activation of the fire alarm system. 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 dining room.</p> <p>Findings include:</p> <p>a. Based on observation with the Buildings Manager on 12/13/13 at 1:35 p.m., a Dutch door separated the kitchen and dining room. The door was equipped with a door knob and self closer on the upper half of the door. A manual latch was provided to secure the upper and lower halves. The doors were open with the upper and lower half separated. When</p>	K010029	<p>A. The door latch will be removed on the lower half of the Dutch door. The upper half of the Dutch door will have a latching device. A catch device will be added to the upper half of the door, so when it closes automatically upon activation of the fire alarm system it will catch and close the lower half of the Dutch door. This item could potentially affect all residents in the facility, as do all areas of fire safety. The Maintenance Director will be the responsible person and will monitor by visibly inspecting all maintenance and construction to ensure that this type of finding does not recur. B. The kick down door stop will be removed and an automatic door holder will installed that will close automatically upon activation of the fire alarm system. This item could potentially affect all residents in the facility, as do all areas of fire safety. The</p>	01/12/2014			

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	<p>the top half of the door was closed the lower half remained open and could not self close and latch into the door frame. The Buildings Manager acknowledged at the time of observation the bottom half of the door could not self close and latch.</p> <p>b. Based on observation with the Buildings Manager on 12/13/13 at 1:40 p.m., the door separating the dining room and kitchen dish room which is open to the main kitchen had no self closer. The Buildings Manager acknowledged at the time of observation the door could not self close and latch.</p> <p>3.1-19(b)</p>		Maintenance Director will be the responsible and will monitor by visibly inspecting all maintenance and construction to ensure that this type of finding does not recur.		

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K010038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure the exit discharge for 1 of 8 emergency exit discharges was arranged to be accessible. LSC 19.2.1 requires compliance with LSC 7.1, Means of Egress. LSC 7.1.3.2.3 requires an exit enclosure shall not be used for any purpose with the potential to interfere with its use as an exit. LSC 7.1.10.1 "Means of egress shall be continuously free of all obstructions or impediments to full instant use in case of fire or other emergency use." This deficient practice affects visitors, staff and 10 or more residents in the dining room.</p> <p>Findings include:</p> <p>Based on observation with the Buildings Manager on 12/13/13 at 1:30 p.m., the discharge path for the dining room exit was covered with a layer of ice and snow. At the time of observation the Buildings Manager agreed, the iced exit discharge could interfere with safe exit to the public way in an emergency.</p> <p>3.1-(19)</p>	K010038	All means of egress will be continuously free of all obstructions or impediments including free of ice and snow. This item could potentially affect all residents in the facility, as do all areas of fire safety. The Maintenance Director will be responsible person and will monitor by visibly inspecting all means of egress to ensure that this type of finding does not occur.	01/12/2014			

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K010070 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation and interview, the facility failed to provide evidence 1 of 1 space heaters was equipped with a heating element which would not exceed 212 degrees Fahrenheit (F). This deficient practice affects visitors staff and 6 or more residents in the front lobby adjacent to the social services office.</p> <p>Findings include:</p> <p>Based on observation on 12/13/13 at 12:45 p.m. with the Buildings Manager, a space heater was in use in the social services office. At the time of record review on 12/13/13 at 3:30 p.m., the Buildings Manager said, and the Administrator confirmed, there was no written policy for the use of space heaters. They had no evidence the space heater element would not exceed 212 degrees Fahrenheit.</p> <p>3.1-19(b)</p>	K010070	<p>Portable space hating devices will only be used in non-sleeping employee areas. The Heating element of such devices will not exceed 212 degrees Fahrenheit. Please see the attached written policy for the use of space heaters. This item could potentially affect all residents in the facility, as do all areas of fire safety. The Maintenance Director will be the responsible person and will monitor by visibly inspecting all areas of the facility to ensure that this type of finding does not recur.</p>	01/12/2014	

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K010073 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4</p> <p>Based on observation and interview, the facility failed to ensure combustible decorations were limited in use in 1 of 7 smoke compartments. This deficient practice could affect visitors, staff, and 10 or more residents in the center smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Buildings Manager on 12/13/13 at 1:00 p.m., the four by eight foot upper half of the corridor wall leading into the activities lounge was covered with fabric, a puzzle and paper decorations. The Buildings Manager said at the time of observation, he had nothing to show the materials were not flammable.</p> <p>3.1-19(b)</p>	K010073	The decoration will be removed so that there is a limited use of decoration on the walls. This item could potentially affect all visitors, staff and residents in the facility, as do all areas of fire safety. The Administrator will be the responsible person and will monitor by visible inspecting the facility to ensure that this type of finding does not recur.	01/12/2014	