

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155253	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2014
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NAME OF PROVIDER OR SUPPLIER  MEADOWOOD HEALTH PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 2455 TAMARACK TR BLOOMINGTON, IN 47408
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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: 08/05/14</p> <p>Facility Number: 000156 Provider Number: 155253 AIM Number: NA</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Meadowood Health Pavilion was found not in compliance with Requirements for Participation in Medicare, 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 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 operated smoke detectors in resident</p>	K010000	<p>Meadowood Retirement Community wishes to point out to any person who reviews this document that we do not necessarily agree with the citations with which we were cited. However, the law requires us to prepare a plan of correction for the citations regardless of whether we agree with them. Thus, we prepared such a plan below. Please note, though, that this plan does not constitute an admission that the citations are either legally or factually correct. This plan of correction is not meant to establish any standard of care, contract, obligation or position, and Meadowood Retirement Community reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding. Please accept September 4, 2014 as the facility's allegation of compliance.</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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K010018 SS=E	<p>sleeping rooms 1 through 11 and 34 through 47 plus hard wired single station smoke detectors in resident sleeping rooms 12 through 33. The facility has a capacity of 66 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.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/07/14.</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 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</p>						

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	<p>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 2 of over 75 corridor doors would close and latch into the door frame and had no impediment to closing. This deficient practice could affect 20 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Executive Director, Physical Plant Director and the Maintenance Assistant during a tour of the facility from 12:45 p.m. to 3:10 p.m. on 08/05/14, the corridor door to the Salon was propped in the fully open position with a wedge and the corridor door to the Nautilus Room was not equipped with a positive latching device. Based on interview at the time of the observations, the Executive Director, Physical Plant Director and the Maintenance Assistant acknowledged the aforementioned corridor door locations had an impediment to closing and latching or were not equipped with a positive latching device to latch the door into the door frame.</p> <p>3.1-19(b)</p>	K010018	<p>Facility Position: The facility has and had at the time of survey, policies and procedures in place to assure proper door closure without being impeded. Plan of Correction: All doors including the Salon door have been inspected and all items causing any impediment have been removed allowing proper door closure. Maintenance staff will be in-serviced to assure understanding of this finding. Administrator will monitor through observations during daily rounds and report any violations to Maintenance Director for immediate remediation. Nautilus Room door has been evaluated and proper latching device has been ordered. Upon delivery, latching device will be installed to bring door into compliance. Maintenance Director and Administrator will ensure proper and timely installation.</p>	09/04/2014

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K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure openings through 1 of 9 smoke barrier walls were protected to maintain the one half hour fire resistance of the smoke barrier. LSC 19.3.7.3 refers to Section 8.3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 10 residents, staff and visitors in the Health Pavilion lobby.</p> <p>Findings include:</p>	K010025	<p>Facility Position: The facility has and had at the time of survey, policies and procedures in place to assure construction and proper maintenance of approved smoke barriers. Plan of Correction: All areas above the ceiling at smoke barrier doors have been inspected. Areas of concern above the doors separating the reception area and the Health Pavilion lobby have been sealed with approved fire barrier caulk. Maintenance staff will be in-serviced to assure understanding of this finding and the requirement to seal all holes made during construction or renovation.</p>	09/04/2014

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K010046 SS=D	<p>Based on observations with the Executive Director, Physical Plant Director and the Maintenance Assistant during a tour of the facility from 12:45 p.m. to 3:10 p.m. on 08/05/14, four two inch in diameter holes for the passage of at least ten cables per hole were noted in the smoke barrier wall above the ceiling by the smoke barrier door set separating the reception area from the Health Pavilion lobby which did not provide at least a one half hour fire resistance rating for the smoke barrier wall. In addition, one of the four holes was sealed with expandable foam which is not an approved material for maintaining the fire resistance of a smoke barrier. Based on interview at the time of the observations, the Maintenance Assistant acknowledged the aforementioned openings in the aforementioned smoke barrier wall did not provide at least a one half hour fire resistance rating.</p> <p>3.1-19(b)</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>						

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	<p>1. Based on record review, observation and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 1 of 2 battery operated lights during the most recent 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 operated emergency lighting system for not less than 1 ½ hour 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 two staff and visitors in the boiler room.</p> <p>Findings include:</p> <p>Based on review of "Battery Light Monthly Check" documentation for 2013 and 2014 with the Executive Director, Physical Plant Director and the Maintenance Assistant during record review from 9:30 a.m. to 12:00 p.m. on 08/05/14, the battery operated emergency light located at the emergency generator location was documented as functional tested for not less than 30 seconds and an annual test on 10/31/13 for not less than</p>	K010046	<p>Facility Position: The facility has and had at the time of survey, policies and procedures in place to assure testing and maintenance of the emergency batter powered light sets in accordance with applicable requirements. Plan of Correction: The battery powered light set located in the boiler room has been added to the current preventative maintenance schedule. This schedule will stipulate the light shall be tested monthly for a 30 second duration. This test will be documented in the preventative maintenance record book. Additionally, a preventative maintenance schedule to test the light annually for 90 minutes has been set up. This test will be documented in the preventative maintenance book. Physical Plant Director will monitor compliance during scheduled monthly PM record checks for 6 months. Any findings will be reported to the Quality of Life committee.</p>	09/04/2014

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	<p>1 ½ hour duration for the most recent twelve month period. Based on observations with the Executive Director, Physical Plant Director and the Maintenance Assistant during a tour of the facility from 12:45 p.m. to 3:10 p.m. on 08/05/14, a total of two battery operated emergency lights were noted in the facility, one at the emergency generator location and a second light in the boiler room. The battery operated emergency light located at the generator operated when the test button was pushed, however, the light located in the boiler room did not. Based on interview at the time of observation, the Maintenance Assistant acknowledged documentation of functional testing for not less than 30 seconds and an annual test for not less than 1 ½ hour duration for the boiler room battery operated emergency light for the most recent twelve month period was not available for review.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 2 battery powered emergency lights was maintained in accordance with LSC 7.9. LSC 7.9.2.4 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided</p>			

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K010052 SS=E	<p>with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. This deficient practice could affect two staff and visitors in the boiler room.</p> <p>Findings include:</p> <p>Based on observations with the Executive Director, Physical Plant Director and the Maintenance Assistant during a tour of the facility from 12:45 p.m. to 3:10 p.m. on 08/05/14, the battery operated emergency light located in the boiler room failed to illuminate when its test button was pressed five times. Based on interview at the time of observation, the Maintenance Assistant acknowledged the aforementioned battery operated emergency light failed to illuminate when its test button was pressed.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is</p>			

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	<p>installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on observation and interview, the facility failed to maintain 1 of 22 smoke detectors in accordance with NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, smoke detectors shall not be located where airflow prevents operation of the detectors. NFPA 72, A-2-3.5.1 explains smoke detectors should not be located in a direct airflow nor closer than 3 feet from an air supply diffuser or return air opening. This deficient practice could affect 18 residents, staff and visitors in the vicinity of the Skilled Nurses Station.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director, Physical Plant Director and the Maintenance Assistant during a tour of the facility from 12:45 p.m. to 3:10 p.m. on 08/05/14, the smoke detector in the corridor by the Skilled Nurses Station was located on the ceiling within six inches of an air supply vent. Based on interview at the time of observation, the Executive Director, Physical Plant Director and the Maintenance Assistant</p>	K010052	<p>Facility Position: The facility has and had at the time of survey, policies and procedures in place to assure the fire alarm system is installed, tested and maintained in accordance with applicable requirements. Plan of Correction: All smoke detectors in the Health Pavilion corridors have been inspected for proper placement in accordance to the rule. The smoke detector in question by the Skilled Nurses Station has been moved an acceptable distance from the air supply vent. Maintenance staff will be in-serviced to assure understanding of this finding.</p>	09/04/2014

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K010062 SS=F	<p>acknowledged the aforementioned smoke detector was located on the ceiling within six inches of an air supply vent.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on record review, observation and interview; the facility failed to ensure 1 of 1 automatic sprinkler systems was inspected every five years as required by NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 10-2.2 states systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice could affect all residents, staff and visitors in the facility.</p>	K010062	<p>Facility Position: The facility has and had at the time of survey, policies and procedures in place to assure testing and maintenance of the automatic sprinkler system in accordance with applicable requirements.</p> <p>Plan of Correction: 1. Appropriate fire system contractor has been contacted and scheduled to complete 5 year internal pipe inspection. Inspection has been scheduled to be completed in a timely manner to insure compliance. Future inspection times will be entered into PM system to properly alert Maintenance Director of upcoming inspection needs. 2. Fire Hydrant will be placed on an annual preventative maintenance inspection. Inspection for year 2014 will be appropriately documented and placed in the preventative maintenance binder.</p>	09/04/2014

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	<p>Findings include:</p> <p>Based on record review with the Executive Director, Physical Plant Director and the Maintenance Assistant from 9:30 a.m. to 12:00 p.m. on 08/05/14, documentation of an internal pipe inspection for the facility's automatic sprinkler system within the most recent five year period was not available for review. Based on observation with the Physical Plant Director and the Maintenance Assistant during a tour of the facility at 3:10 p.m. on 08/05/14, 03/24/09 was written on the sprinkler system riser in the kitchen pantry as the date of the most recent internal pipe inspection. Based on interview at the time of record review and of the observation, the Physical Plant Director and the Maintenance Assistant stated an internal pipe inspection was due this year but has not yet been scheduled and acknowledged it has been more than five years since the most recent internal pipe inspection was performed.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure 1 of 1 private fire hydrants was continuously maintained in reliable operating condition and inspected and tested periodically.</p>		<p>Future inspection times will be entered into PM system to properly alert Maintenance Director of upcoming inspection needs.</p>				

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	<p>NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Executive Director, Physical Plant Director and the Maintenance Assistant from 9:30 a.m. to 12:00 p.m. on 08/05/14, documentation of facility fire hydrant inspection within the last year was not available for review. Based on interview at the time of record review, the Maintenance Assistant stated one facility owned fire hydrant is located in the front parking lot and acknowledged documentation of a facility owned fire hydrant inspection within the last year was not available for review.</p> <p>3.1-19(b)</p>			

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K010064 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to inspect 1 of 20 portable fire extinguishers in the facility each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the Salon.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director, Physical Plant Director and the Maintenance Assistant during a tour of the facility from 12:45 p.m. to 3:10 p.m. on 08/05/14, the annual maintenance tag attached to the portable fire extinguisher</p>	K010064	<p>Facility Position: The facility has and had at the time of survey, policies and procedures in place to assure portable fire extinguishers are checked monthly in accordance with applicable requirements. Plan of Correction: A revised preventative maintenance program has been developed to assure all fire extinguishers are inspected during the monthly check. This check will be documented in the preventative maintenance record book. Maintenance staff will be in-serviced to assure understanding of new procedure, documentation and what to check for each month. Maintenance Director will monitor compliance during scheduled monthly PM record checks for 6 months. Any findings will be reported to the Quality of Life committee</p>	09/04/2014

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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
K010130 SS=C	<p>located in the Salon indicated a monthly inspection was not documented for June and July 2014. Based on interview at the time of observation, the Maintenance Assistant stated monthly fire extinguisher checks are performed on the night shift when the Salon is locked, no additional documentation of monthly fire extinguisher checks was available for review and acknowledged a monthly inspection for the portable fire extinguisher located in the Salon was not documented for June and July 2014.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and interview; the facility failed to maintain a preventive maintenance program for battery operated smoke detectors installed in 47 of 47 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice could affect all residents, staff and visitors.</p>	K010130	<p>Facility Position: The facility has and had at the time of survey, policies and procedures in place to assure proper preventative maintenance on battery operated smoke detectors in accordance with applicable requirements. Plan of Correction: Current smoke detector preventative maintenance program has been revised to include monthly cleaning to be completed during current monthly battery checks. This check will be documented</p>	09/04/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155253		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  08/05/2014	
NAME OF PROVIDER OR SUPPLIER  MEADOWOOD HEALTH PAVILION				STREET ADDRESS, CITY, STATE, ZIP CODE 2455 TAMARACK TR BLOOMINGTON, IN 47408			
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	<p>Findings include:</p> <p>Based on review of "Smoke Detector Monthly Check" for October 2013 through August 1, 2014 with the Executive Director, Physical Plant Director and the Maintenance Assistant from 9:30 a.m. to 12:00 p.m. on 08/05/14, resident sleeping room battery operated smoke detector cleaning documentation within the most recent twelve month period was not available for review. Based on observations with the Executive Director, Physical Plant Director and the Maintenance Assistant during a tour of the facility from 12:45 p.m. to 3:10 p.m. on 08/05/14, manufacturer's specifications affixed to First Alert Model 9120B and Universal Model 2975 battery operated smoke detectors stated to clean once per month. Based on interview at the time of record review and of the observations, the Maintenance Assistant acknowledged documentation of battery operated smoke detector cleaning for the most recent twelve month period was not available for review.</p> <p>3.1-19(a)</p>		<p>monthly in the preventative maintenance record book. Maintenance staff will be in-serviced to assure understanding of new procedure and documentation requirements. Maintenance Director will monitor compliance during scheduled monthly PM record checks for 6 months. Any finding will be reported to the Quality of Life committee</p>				

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K010147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 18 residents, staff and visitors in the vicinity of Room 4.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director, Physical Plant Director and the Maintenance Assistant during a tour of the facility from 12:45 p.m. to 3:10 p.m. on 08/05/14, an Invacare oxygen concentrator in resident sleeping Room 4 was plugged into a power strip located under the bed. Based on interview at the time of observation, the Executive Director, Physical Plant Director and the Maintenance Assistant acknowledged a power strip was in use as a substitute for fixed wiring in Room 4.</p> <p>3.1-19(b)</p>	K010147	<p>Facility Position: The facility has and had at the time of survey, policies and procedures in place to assure electrical wiring is in accordance with applicable requirements. Plan of Correction: All resident rooms have been reviewed and audited to assure all power strips are being used according to requirements and that no medical equipment nor high output equipment are using power strips for supply. Proper use of power strips will be reviewed with all Health Pavilion staff and Maintenance staff. Staff is to report any improper use immediately for corrective measures. Administrator will monitor through observations during daily rounds and report any violations to Maintenance Director for immediate correction.</p>	09/04/2014

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

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