

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155690	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/22/2012
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NAME OF PROVIDER OR SUPPLIER MEADOW BROOK REHABILITATION CENTRE & SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 1821 LINDBERG RD ANDERSON, IN 46012
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K0000	<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: 02/22/12</p> <p>Facility Number: 000027 Provider Number: 155690 AIM Number: 100266180</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Meadow Brook Rehabilitation Centre & Suites 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 fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and none in the resident rooms. The facility</p>	K0000	<p>Submission of this plan of correction does not constitute an admission to or an agreement with the facts alleged on the survey report.</p> <p>Submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies.</p> <p>The plan of correction is prepared and submitted because of requirements under State and Federal law.</p> <p>Please accept this plan of correction as our credible allegation of compliance.</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.

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	<p>has a capacity of 97 and had a census of 71 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/01/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0018 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.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 22 corridor doors on hall 4 would latch into its frame. This deficient practice could affect 6 residents on hall 4 as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 02/22/12 at 1:20 p.m. with the Maintenance Supervisor, the door leading into the wheelchair storage room which is next to hall 4 smoke doors would not latch into its frame. Based on interview on 02/22/12 at 1:24 p.m. with the Maintenance Supervisor, it was acknowledged the aforementioned door would not latch into its frame.</p>	K0018	<p>I. The door leading into the wheelchair storage room next to hall 4 smoke doors has been repaired to latch appropriately into its frame. II. All residents and staff in the vicinity of the wheelchair room near hall 4 have the potential of being affected. III. An audit of all doors in the facility was conducted to ensure all doors requiring the ability to latch, did have that capability. No further deficiencies were noted. IV. As a means of quality assurance, all doors requiring latching devices will be checked monthly and findings noted on the monthly preventative maintenance log. Should findings be noted, corrective action shall be implemented. Results of the aforementioned audits and immediate corrective actions taken shall be reported to the quality assurance committee on a</p>	03/14/2012

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	3.1-19(b)		quarterly basis for review and recommended revision of monitoring, if warranted.		

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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 2 of 3 doors leading to hazardous areas such as rooms with combustibile items and kitchens were provided with self closing devices which would cause the doors to automatically close and latch into the door frames. This deficient practice affects 24 residents on hall 2 and 6 residents observed in the dining room adjacent to the kitchen as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 02/22/12 during the tour between 12:05 p.m. and 1:02 p.m. with the Maintenance Supervisor, the activities supply room on hall 2 had twenty five cardboard boxes, was greater than fifty square feet in size and lacked a self closing device on the corridor door. In addition, the kitchen on center hall</p>	K0029	<p>I. The activities closet door and the north door leading into the kitchen have been equipped with positive self closing devices. II. All residents, staff, and visitors have the potential to be affected. III. An audit of all entry doors into hazardous areas was conducted to ensure all doors contained a positive latching device. No further deficiencies were noted. IV. As a means of quality assurance, all entry doors into hazardous areas will be checked for proper latching weekly and findings noted on the weekly preventative maintenance log. Should noncompliance be noted, corrective action shall be implemented. Results of the aforementioned audits and immediate corrective actions taken will be reported to the quality assurance committee on a quarterly basis for review and recommended revision of monitoring, if warranted.</p>	03/14/2012			

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	<p>which was adjacent to the main dining room lacked a closer on the north door leading into the kitchen. Based on interview on 02/22/12 concurrent with the observations with the Maintenance Supervisor, it was acknowledged the aforementioned doors leading into the activities supply room and the kitchen were not equipped with a self closing devices on the doors.</p> <p>3.1-19(b)</p>			

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K0038 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 exit access was arranged so 1 of 13 exits was readily accessible at all times in accordance with LSC Section 7.1. LSC Section 7.1.10.1 requires means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. LSC Section 7.1.6.4 requires walking surfaces shall be slip resistant under foreseeable conditions. This deficient practice could affect 18 residents on hall 6 as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 02/22/12 at 2:22 p.m. with the Maintenance Supervisor, the cement walkway used to discharge hall 6 residents was cracked and partly in rubble the last four feet before entering the public way. Based on interview on 02/22/12 at 2:25 p.m. with the Maintenance Supervisor, it was acknowledged the concrete walk just outside the hall 6 exit was cracked with rubble creating an uneven slippery surface for residents to walk on while evacuating the building.</p>	K0038	<p>I. The cement walkway outside of hall 6 has been repaired and debris has been cleared. II. All residents, staff, and visitors have the potential to be affected. III. An audit of the facility grounds was conducted to ensure all walkways were in good repair and surfaces were even and not slippery for safety of residents, staff, and visitors. No further deficiencies were noted. IV. As a means of quality assurance, facility grounds will be inspected weekly to ensure all walkways will be even, not slippery, and free from debris to ensure safe evacuation routes and travel. Should deficiencies be noted, immediate corrective action shall be implemented. Results of the aforementioned audits and immediate corrective actions taken will be reported to the quality assurance committee on a quarterly basis for review and recommended revision of monitoring, if warranted.</p>	03/14/2012			

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K0064 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 maintain 1 of 2 portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2- 3.2 requires fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect any residents using the main dining room, located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 02/22/12 at 2:38</p>	K0064	I. A placard has been conspicuously placed near the extinguisher in the kitchen which states the fire suppression system will be used prior to using the portable extinguisher. II. All residents, staff, and visitors using the main dining room have the potential to be affected. The area requiring a placard near the "K" class extinguisher in the kitchen is now up to code.	03/14/2012			

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	<p>p.m. with the Maintenance Supervisor, there was a K class extinguisher conspicuously placed next to the entry door to the kitchen, but it lacked a placard. Based on interview on 02/22/12 at 2:40 p.m. with the Maintenance Supervisor, it was acknowledged the K class portable fire extinguisher was not provided with a placard.</p> <p>3.1-19(b)</p>				

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K0066 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation, record review and interview; the facility failed to ensure cigarette butts were deposited into a noncombustible container for 2 of 2 areas where smoking was permitted. This deficient practice could affect 5 residents observed in the smoke hut and 18 residents on hall 6 as well as visitors and residents.</p> <p>Findings include:</p> <p>Based on observation on 02/22/12 at 2:55 p.m. with the Maintenance Supervisor, a</p>	K0066	<p>I. The plastic 30 gallon container for paper goods was removed from the "smoking hut" and replaced with a metal container with a self closing cover. The plastic 10 gallon container for paper goods was removed from the staff smoking area. The grounds around both smoking areas were cleaned as well as the area north of the employee smoking area. II. All residents and staff have the potential to be affected. III. An audit was conducted of the facility grounds to ensure grounds were free of cigarette butts and areas outside</p>	03/14/2012	

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	<p>plastic thirty gallon trash container used for paper goods in the smoking hut just outside the dining room on center hall exit was used for the disposal of one hundred cigarette butts. Furthermore, the designated smoking area for staff located just outside hall 6 used a ten gallon plastic container used for disposal of paper goods to dispose of six cigarette butts. Also, fifty cigarette butts were observed on the ground just north of where staff were observed smoking. Based on review of the smoking policy on 02/22/12 at 4:15 p.m. with the Maintenance Supervisor, the smoking policy did address the proper disposal of extinguished cigarette butts. Based on interview on 02/22/12 at 2:59 p.m. with the Maintenance Supervisor, it was acknowledged the facility's employees disposed of cigarette butts into unapproved plastic containers with paper goods, or on the ground.</p> <p>3.1-19(b)</p>		<p>of building were equipped with appropriate trash receptacles as needed. No further deficiencies were noted. IV. As a means of quality assurance, facility grounds will be inspected daily to ensure smoking areas are free of cigarette butts and are equipped with the appropriate trash receptacles. Should noncompliance be noted, corrective action shall be implemented. Results of the aforementioned audits and corrective action taken will be reported to the quality assurance committee on a quarterly basis for review and recommended revision of monitoring, if warranted.</p>		

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K0143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage rooms where oxygen transfer occurs had continuously working, electrically powered mechanical ventilation which could not be turned off. This deficient practice could affect 18 residents observed on hall 1 as well as visitors and staff in the area.</p> <p>Findings include:</p> <p>Based on observation on 02/22/12 at 12:46 p.m. with the Maintenance Supervisor, the oxygen storage room on hall 1 used to store and transfer oxygen was provided with electrically powered mechanical ventilation, but could be turned off and on with the light switch.</p>	K0143	<p>I. The switch to both the light and mechanical vent has been removed to ensure both the light and mechanical vent will be operating continuously. II. The residents on hall 1 as well as visitors and staff have the potential to be affected. III. As a means to ensure ongoing compliance the light and mechanical vent will be monitored for proper functioning. Should any noncompliance occur, corrective action will be taken immediately.</p>	03/14/2012			

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	<p>The light and the mechanical vent were on the same switch. Based on interview on 02/22/12 at 12:50 p.m. it was acknowledged by the the Maintenance Supervisor this room was used to transfer oxygen and though it had an electrically powered mechanical vent, it could be turned on and off with the light switch and no precautions were evident to ensure the light switch would remain on.</p> <p>3.1-19(b)</p>			