

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 10/30/2013
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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: 10/30/13</p> <p>Facility Number: 000156 Provider Number: 155253 AIM Number: N/A</p> <p>Surveyor: Lex Brashear, 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 was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, in spaces open to the corridors, and battery operated smoke detectors in resident sleeping</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 November 29, 2012 as the facility's 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>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 55 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/04/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010046 SS=C	<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 and interview, the facility failed to ensure the documentation for the testing of 1 of 1 battery powered light sets was complete when testing monthly for 30 seconds and annually for 90 minutes. LSC 101, Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. 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. NFPA 110, Section 5-3.1 requires EPS (Emergency Power Supply) equipment locations shall be provided with battery powered emergency lighting. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the Monthly Generator Log in the Life Safety Book on 10/30/13 at 12:25 p.m. with the Executive</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 requirments.Plan of Correction: The battery powered light set located by the generator has been placed on a 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 maintenace record book. Additionally, a preventative maintanance schedule to test the light annually for 90 minutes has been set up. This test will be documented in the preventative maintenance record book. The administrator will monitor compliance during scheduled monthly PM record checks. Any findings will be reported to the Quality of Life committee.</p>	11/29/2013			

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	<p>Director, Maintenance Director and Maintenance Assistant # 1 present, there was documentation to show the battery back up light set over the generator was tested monthly, however, it did not indicate the test was for at least thirty seconds. Furthermore, there was no documentation to show the battery back up light set was tested for ninety minutes annually within the past twelve months. This was confirmed by Maintenance Assistant # 1 at the time of record review.</p> <p>3-1.19(b)</p>			

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K010048 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>Based on record review and interview, the facility failed to provide a complete written fire safety plan for the protection of 55 of 55 residents to accurately address all life safety systems such as the transmission of the fire alarm to the monitoring company/fire department, the evacuation of the smoke compartment, the use of all fire extinguishers including the K-class fire extinguisher in the kitchen, and staff response to battery operated or single station smoke detectors in resident sleeping rooms, plus a system addressing all items required by NFPA 101, 2000 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all occupants in the event of an emergency.</p>	K010048	<p>Facility Position: The facility has and had at the time of survey, policies and procedures in place to provide a fire safety plan in accordance with applicable requirements</p> <p>Plan of Correction: Fire Safety plan will be evaluated and appropriate changes made to address the alleged missing information including but not limited to, the transmission of the fire alarm to the monitoring company/fire department, evacuation of the smoke compartment, the use of all fire extinguishers including the K-class fire extinguisher in the kitchen plus the K-class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system, and staff response to battery operated or single station smoke detectors in resident sleeping rooms. The newly updated fire plan will be placed in disaster plans located in the building. Staff will be inserviced on the changes. Administrator and Maintenance director will review the fire plan annually. Any findings and changes will be presented to the Quality of Life committee.</p>	11/29/2013			

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	<p>Findings include:</p> <p>Based on a review of the Fire and Disaster Plan Procedure on 10/30/13 at 12:00 p.m. with the Executive Director, Maintenance Director and Maintenance Assistant # 1 present, the Fire and Disaster Plan Procedures did not address the transmission of the fire alarm to the monitoring company/fire department, evacuation of the smoke compartment, the use of all fire extinguishers including the K-class fire extinguisher in the kitchen plus the K-class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system, and staff response to battery operated or single station smoke detectors in resident sleeping rooms. Based on interview at the time of record review, the Executive Director acknowledged the Fire and Disaster Plan Procedure did not include the previously mentioned items.</p> <p>3.1-19(b)</p>				

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K010130 SS=F	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and interview; the facility failed to document the maintenance of 25 of 25 battery operated smoke detectors in resident rooms to ensure the smoke detectors are continually operable. NFPA 101 in 4.6.12.2 states existing life safety features obvious to the public, if not required by the Code, shall either be maintained or removed. This deficient practice could affect up to 36 residents, staff, and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observation on 10/30/13 between 12:45 p.m. and 2:00 p.m. during a tour of the facility with the Executive Director, Maintenance Director and Maintenance Assistant # 1, battery operated smoke detectors were observed in resident sleeping rooms 1 through 11, and 34 through 47. Based on interview with Maintenance Assistant # 1 during record review on 10/30/13 at 12:15 p.m., the facility utilizes battery operated smoke detectors in resident sleeping rooms 1 through 11 and 34 through 47. Furthermore, Maintenance Assistant # 1 indicated the batteries in the battery operated smoke detectors in these resident</p>	K010130	<p>Facility Position: The facility has and had at the time of survey, policies and procedures in place to assure testing and maintenance of resident room smoke detectors in accordance with applicable requirements. Plan of Correction: The battery operated smoke detectors in resident rooms have been placed on a preventative maintenance schedule. This schedule will stipulate the smoke detectors shall be tested monthly for proper operation. These tests will be documented in the preventative maintenance record book. Additionally, a preventative maintenance schedule to replace the battery in each detector will be completed annually has been set up. The changing of batteries will be documented in the preventative maintenance record book. The administrator will monitor compliance during scheduled monthly PM record checks. Any findings will be reported to the Quality of Life committee.</p>	11/29/2013			

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	<p>sleeping rooms have been changed within the past twelve months, however, he said there was no written documentation to show monthly tests of each battery operated smoke detector, or documentation to show when the batteries were changed.</p> <p>3.1-19(b)</p>			