

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155325	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/02/2016
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NAME OF PROVIDER OR SUPPLIER  MEADOW VIEW HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 900 ANSON ST SALEM, IN 47167
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K 0000  Bldg. 01	<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: 09/02/16</p> <p>Facility Number: 000218 Provider Number: 155325 AIM Number: 100274800</p> <p>At this Life Safety Code survey, Meadow View Health and Rehabilitation 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 (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 98 and had a census of</p>	K 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after.	
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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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K 0052 SS=E Bldg. 01	<p>69 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has two detached wooden storage sheds which were not sprinkled.</p> <p>Quality Review completed on 09/07/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7,</p> <p>Based on observation and interview, the facility failed to ensure 1 of 49 photoelectric smoke detectors was not located where airflow would prevent the operation of the detector. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could affect 16 residents who use the North dining room.</p>	K 0052	<ul style="list-style-type: none"> <li>·Theidentified fan in the North dining room has been removed so that it was not impedingthe airflow to the smoke detector.</li> <li>·Allother smoke detectors in the facility were observed and no other issues werenoted.</li> <li>·TheMaintenance Staff will be in-serviced on NFPA 72 2-3.5.1. by ED/CEC.</li> <li>·TheMaintenance Director and/or designee will complete environmental rounds toensure no other smoke detectors are located where they could be impeded byairflow weekly x 4 weeks, monthly x 2 months, and</li> </ul>	09/14/2016

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K 0143 SS=E Bldg. 01	<p>Findings include:</p> <p>Based on observation on 09/02/16 at 10:20 a.m. with the maintenance supervisor, the north dining room smoke detector located on the east side of the dining room was located one foot from a ceiling fan. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 09/02/16 at 11:30 a.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:</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; and (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association.</p> <p>8-6.2.5.2 (NFPA 99) Based on observation and interview, the</p>	K 0143	<p>quarterly times 3 quarters. Results of these audits will be reviewed during QA committee and actions plans will be developed as needed until 100% compliance is achieved.</p> <p>The paint in the identified oxygen storage room has been</p>	09/14/2016			

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	<p>facility failed to ensure 1 of 1 liquid oxygen transfer area was provided with a ceramic or concrete floor. This deficient practice could affect 6 residents who use the Administration Hall corridor located near the liquid oxygen storage room.</p> <p>Findings include:</p> <p>Based on observation on 09/02/16 at 11:15 a.m. with the maintenance supervisor, the Administration Hall liquid oxygen storage room, where six full liquid oxygen containers were stored, had a concrete floor painted with gray paint. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 09/02/16 at 11:30 a.m.</p> <p>3.1-19(b)</p>		<p>removed.</p> <ul style="list-style-type: none"> <li>·Allother areas that are used as oxygen storage were observed and no other issues noted.</li> <li>·TheMaintenance staff will be in-serviced on NFPA 8-6.2.5.2 by the ED/CEC.</li> <li>·TheMaintenance Director and/or designee will complete environmental rounds to ensure no other oxygen storage rooms have paint on the floor weekly x 4 weeks, monthly x 2 months, and quarterly times 3 quarters. Results of these audits will be reviewed during QA committee and actions plans will be developed as needed until 100% compliance is achieve.</li> </ul>		