

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155358 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 11/18/2013 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER MEADOWS MANOR EAST | STREET ADDRESS, CITY, STATE, ZIP CODE 3300 POPLAR ST TERRE HAUTE, IN 47803 |
|--|--|

| (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 |
|--------------------|--|---------------|---|----------------------|
| 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: 11/18/13</p> <p>Facility Number: 000249 Provider Number: 155358 AIM Number: 100267640</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Meadows Manor East 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 with a basement was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. Battery powered smoke detectors are provided in</p> | K010000 | <p>Please consider this Plan of Correction as our allegation of compliance. Disclaimer: Meadows Manor Convalescent and Rehab Center does not believe and does not admit that any deficiencies existed before, during or after the survey. Meadows Manor Convalescent and Rehab Center reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. His plan of correction is not meant to establish any standard of care, contract obligation or position and Meadows Manor Convalescent and Rehab Center 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 potentially applicable peer review, quality assurance or self critical examination privileges which Meadows Manor Convalescent and Rehab Center does not waive, and reserves the right to assert in any administrative civil or criminal claim, action or proceeding. Meadows Manor Convalescent and Rehab Center offers its responses, credible allegations of compliance and plan of correction as part of its ongoing effort to provide quality</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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155358 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 11/18/2013 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER MEADOWS MANOR EAST | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3300 POPLAR ST TERRE HAUTE, IN 47803 | | |
| (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 | |
| | <p>all resident rooms. The facility has the capacity for 89 and had a census of 65 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 11/20/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p> | | care to its residents | | |

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155358 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 11/18/2013 | |
| NAME OF PROVIDER OR SUPPLIER MEADOWS MANOR EAST | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3300 POPLAR ST TERRE HAUTE, IN 47803 | | | |
| (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 | | | |
| K010025 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD 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 in a ceiling smoke partition were sealed to limit the transfer of smoke in 1 of 6 smoke compartments. LSC 8.2.4.1 requires smoke partitions shall limit the transfer of smoke. This deficient practice could affect visitors, staff and 10 or more residents in the main dining room smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance man and buildings manager on 11/18/13 at 9:40 a.m., the meeting edge of the lay in ceiling and fireplace wall in the dining room had a half inch unsealed gap for a length of six feet. There was also an unsealed two inch cut out of the lay in ceiling tile along this opening. A sprinkler escutcheon near the fire place hung away from the ceiling tile</p> | K010025 | All smoke barriers will be sealed with an approved material to maintain the smoke resistance of each smoke barrier. 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 | 12/18/2013 | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155358 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 11/18/2013 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER MEADOWS MANOR EAST | STREET ADDRESS, CITY, STATE, ZIP CODE 3300 POPLAR ST TERRE HAUTE, IN 47803 |
|--|--|

| (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 |
|--------------------|--|---------------|---|----------------------|
| | <p>leaving a half inch gap. Above the dining room ceiling tiles, the two inch cutout for the sprinkler pipe was unsealed into the attic space above. Additionally, there were two unsealed holes in the ceiling above the lay in tiles. The maintenance man said at the time of observation, he didn't know the gaps had not been sealed.</p> <p>3.1-19(b)</p> | | | |

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155358 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 11/18/2013 | |
| NAME OF PROVIDER OR SUPPLIER MEADOWS MANOR EAST | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3300 POPLAR ST TERRE HAUTE, IN 47803 | | | |
| (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 | | | |
| K010046 SS=D | <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>1. Based on observation and interview, the facility failed to ensure 1 of 2 battery powered emergency lighting fixtures would operate. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This deficient practice affects visitors and 2 staff in the basement boiler room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance man and buildings manager on 11/18/13 at 11:30 a.m., the battery powered emergency light fixture in the boiler room failed to illuminate when tested twice. The maintenance man said at the time of observation, he did not know the light was not working.</p> <p>3.1-19 (b)</p> <p>2. Based on record review and interview, the facility failed to provide documentation of 30 second periodic testing at 30 day intervals and annual testing for 1 1/2 hours of 1 of 2 battery powered emergency lighting fixtures. LSC 7.9.3 requires a functional test shall be conducted on every required battery</p> | K010046 | <p>#1-The facility will ensure that all battery emergency lighting fixtures will operate and be capable of repeated automatic operation. The battery operated emergency light located in the boiler room is not required by code and will be removed. This item could potentially affect all residents as well as visitors and staff, as do all areas of fire safety. The facility maintenance supervisor will be the responsible person and will monitor the operation of the battery light fixtures, by uses of the attached chart, "battery power emergency task light for generator site and transfer switch location", to ensure that type of finding does not recur. #2-The facility will ensure to provide documentation of a function test on all battery powered emergency lighting system at 30 day intervals for 30 seconds and annual tested for 1 ½ hours. This item could potentially affect all residents in the facility, as do all areas of fire safety. The facility maintenance supervisor will be the responsible person and will monitor the uses of the attached chart, "Battery power emergency task light for generator site and transfer switch location", to ensure that this type of finding does not recur</p> | 12/18/2013 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155358 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 11/18/2013 | |
|--|---|---|---|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER MEADOWS MANOR EAST | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3300 POPLAR ST TERRE HAUTE, IN 47803 | | | |
| (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 | | | |
| | <p>powered emergency lighting system at 30 day intervals for not less than 30 seconds and an annual test shall be conducted for not less than 1 1/2 hours. Written records of visual inspections and tests shall be kept. This deficient practice affects visitors and 2 staff in the basement boiler room.</p> <p>Findings include:</p> <p>Based on review of facility fire safety inspection and preventive maintenance records with the maintenance man and buildings manager on 11/18/13 at 11:45 a.m., the Battery Powered Emergency Task Lighting records did not include documentation of 30 second monthly and 1 1/2 hour annual tests for the boiler room battery powered emergency lighting fixture. The maintenance man said at the time of record review, he had not been checking this fixture.</p> <p>3.1-19(b)</p> | | | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155358 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 11/18/2013 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER MEADOWS MANOR EAST | STREET ADDRESS, CITY, STATE, ZIP CODE 3300 POPLAR ST TERRE HAUTE, IN 47803 |
|--|--|

| (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 |
|--------------------------|--|---------------------|--|----------------------------|
| | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155358 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 11/18/2013 | |
|--|---|---|--|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER MEADOWS MANOR EAST | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3300 POPLAR ST TERRE HAUTE, IN 47803 | | | |
| (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 | | | |
| 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>1. Based on observation and interview, the facility failed to ensure flexible cords and multi tap adapters were not used as a substitute for fixed wiring in 3 of 6 smoke compartments. NFPA 70, National Electrical Code, 1999 Edition, 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 staff, visitors and 10 or more residents in the west, center and north smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance man and buildings manager on 11/18/13 between 9:15 a.m. and 10:45 a.m., extension cords or unapproved multitap outlet adapters were used to provide power to equipment in the following areas:</p> <ul style="list-style-type: none"> a. Housekeeping Office, power strip for microwave; b. Social Services Office, power strip piggy backed to multitap adapter; c. Physical Therapy Office, multitap adapter. | K010147 | <p>#1- The facility will ensure that all electrical wiring and equipment are in accordance with NFPA 70. All flexible cords and multi tap outlet adapters will be removed. This could potentially affect all residents as well as visitors and staff, 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. #2-The facility will ensure that all electrical junction boxes have covers. 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</p> | 12/18/2013 | | | |

| | | | | | | | |
|--|--|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155358 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 11/18/2013 | |
| NAME OF PROVIDER OR SUPPLIER MEADOWS MANOR EAST | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3300 POPLAR ST TERRE HAUTE, IN 47803 | | | |
| (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 | | | |
| | <p>The maintenance director and buildings manager said at the times of observation, the use of this equipment was not authorized.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure electrical wiring connections in 1 of 6 smoke compartments were maintained in a safe operating condition which included junction boxes. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect visitors, staff and 10 or more residents in the main dining room smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance man and buildings manager on 11/18/13 at 10:00 a.m., two junction boxes behind supplies stored in the attic above the main dining room were uncovered with multiple wires exposed. The maintenance man said said at the time of observation, he did not know the boxes had no covers.</p> <p>3.1-19(b)</p> | | | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155358 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 11/18/2013 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER MEADOWS MANOR EAST | STREET ADDRESS, CITY, STATE, ZIP CODE 3300 POPLAR ST TERRE HAUTE, IN 47803 |
|--|--|

| (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 |
|--------------------------|--|---------------------|--|----------------------------|
| | | | | |