STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155325	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW VIEW HEALTH AND REHABILITATION CENTE	900 ANSON ST SALEM, IN 47167

(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
F000000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00151656. Complaint IN00151656 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: July 27, 28, 29, 30, 31 and August 1, 2014 Facility Number: 000218 Provider Number: 155325 Aim Number: 100274800 Survey Team:. Gloria J. Reisert MSW, TL Gwen Pumphrey RN (7/27, 7/28, 7/29, and 7/30/14) Jenny Sartell, RN Census Bed Type: SNF/NF: 81 Total: 81 Census Payor Type: Medicare: 11 Medicaid: 59 Other: 11 Total: 81	F000000	*"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report." The facility would like to rquest that a desk review be completed for this plan of correction.*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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: 155325	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2014
NAME OF PROVIDER OR SUPPLIER MEADOW VIEW HEALTH AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 ANSON ST SALEM, IN 47167	

(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
	These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality Review completed on August 8, 2014, by Brenda Meredith, R.N.			
F000371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure food was prepared and served in a clean environment, and to ensure staff used proper handwashing procedures. The facility also failed to ensure the walk-refrigerator was maintained at a proper temperature. This deficient practice had the potential to effect 79 of 81 residents served by the kitchen. Findings include: 1. During the initial kitchen tour on 7/26/14 between 2:40 and 3:00 p.m., the following was observed: a. The walk-in refrigerator had a	F000371	The walk-in cooler was cleaned inside and out removing any dust from the condenser fan, ceiling, and top wiring that was identified. The thermometer was removed and replaced by 3 new thermometers inside the walk-in cooler. The insects were removed from the identified fixture. The spider web was removed from the fire door Identified Culinary Assistant's 1 and 2 and Cook # 1 were in-serviced on Hand washing and proper use of gloves in food preparation. A deep clean was preformed in the kitchen to ensure that no other areas were affected by dust, spider webs, and bugs. Dietary staff will be in-serviced on	08/31/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155325	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/01/2014
NAME OF PROVIDER OR SUPPLIER MEADOW VIEW HEALTH AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 ANSON ST SALEM, IN 47167	

(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
	moderate amount of dust on the ceiling directly above the condenser fan. b. The condenser fan had a moderate amount of dust swaying up and down with the air circulation. c. The thermometer cover on the outside of the walk-in refrigerator was cracked. Cook #2 indicated the outside thermometer did not work. The inside temperature was 32 degrees Fahrenheit (F). d. The pipes and wiring outside and above the walk-in refrigerator had a moderate amount of thick dust hanging down and moving back and forth with the breeze. e. There were pieces of lettuce, macaroni and dried cereal on the floor in the food prep area. f. The light fixture across from the fire door exit in the back of the kitchen was observed to have between 10-12 dead insects. g. The fire door was observed to have a large, thick spider web in the top right corner.		facilities Hand Washing, Dietary glove use, temperature monitoring and recording, and Sanitation policy and procedure. It is the responsibility of the dietary staff to wash hands as per expectation, wear gloves as appropriate, and clean the dietary department as per schedule, up to and including bug, spider, and dust debris. Dietary manager and/or designee will conduct a sanitation check 3 times per week for 4 weeks, 1 time per week for 5 months, and monthly times 6 months. Walk-in cooler temps of all 3 new thermometers will be recorded 3 times per day for 4 weeks, 1 times per week for 5 months, monthly per facility policy ongoing. Any issue identified will be immediately corrected, 1:1 re-education completed. Any further identification of non compliance will result in disciplinary action, up to and including termination. The ADM/designee will be responsible to review completed audits as per the identified schedule. Audit results will be reviewed and discussed with QPI committee monthly times 12 months. Any further action will be as determined by the QPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155325	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2014
NAME OF PROVIDER OR SUPPLIER MEADOW VIEW HEALTH AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 ANSON ST SALEM, IN 47167	

(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
	2. On 7/27/14 at 11:10 a.m., Culinary Assistant (CA) #2 was observed with frozen cookie dough in her left hand, placing them on a cookie sheet with her right hand. She was not wearing gloves. On 7/27/14 at 11:35 a.m., CA #1 was observed to re-enter the kitchen and washed her hands for 7 seconds. On 7/27/14 at 11:45 a.m., CA #1 was observed to re-enter the kitchen and washed her hands for 6 seconds On 7/27/14 at 11:50 a.m., CA #1 was observed retrieving dressing from the walk-in refrigerator then washed her hands for 8 seconds. On 7/27/14 at 11:55 a.m., CA #1 was observed to re-enter the kitchen and washed her hands for 10 seconds. On 7/27/14 at 11:56 a.m., Cook #1 was observed to carry tomato juice and bread to staff at the kitchen door with her bare finger touching the corner of the bread. She washed her hands for 6 seconds. On 7/27/14 at 12:00 p.m., CA #1 was observed to retrieve a tomato with her bare hands. She donned one glove to her right hand. While holding the tomato			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155325	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2014
NAME OF PROVIDER OR SUPPLIER MEADOW VIEW HEALTH AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 ANSON ST SALEM, IN 47167	

(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
	with her left bare hand, she cut it in pieces with her right gloved hand. She did not use a cutting board nor did she sanitize the surface after she was finished. On 7/27/14 at 12:01 p.m., CA #1 indicated the tomato she was cutting should have been on a cutting board and she should have had gloves on both hands. On 7/27/14 at 12:05 p.m., CA #1 was observed to re-enter the kitchen and washed her hands for 5 seconds. On 7/27/14 at 12:10 p.m., CA #2 was observed to walk over to the refrigerator, remove an item and return to the serving line. She did not wash her hands. On 7/27/14 at 12:14 p.m., CA #1 was observed to re-enter the kitchen and washed her hands for 6 seconds. On 7/27/14 at 12:15 p.m., CA #2 was observed to enter the kitchen, washed her hands for 5 seconds, turn off the water with her bare hands and dry her hands with a paper towel. She then began loading desserts on cart. On 7/27/14 at 12:20 p.m., Cook #1 indicated "You wash your hands upon			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155325	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/01/2014
NAME OF PROVIDER OR SUPPLIER MEADOW VIEW HEALTH AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 ANSON ST SALEM, IN 47167	

(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
	entering the kitchen, before you put on gloves and anytime there is direct contact with food or surfaces." She also indicated one was supposed wash their hands for 20 seconds. On 7/27/14 at 12:21 p.m., CA #2 indicated one would wash their hands for 45 seconds. On 7/27/14 at 12:25 p.m., CA #1 indicated "You wash your hands for 5 seconds and turn off water with a paper towel." On 7/29/14 at 8:30 a.m., the Policy and Procedure titled, Nutrition Services Practice Manual, 7.32.1 Sanitation Procedure, was provided by the Administrator. It included, but was not limited to, the following: "Procedure: Preparation: Conserve nutritive value, enhance flavor, and prevent foodborne illness. 1. Wash hands properly and as often as needed...f. Rub hands together vigorously for 20 seconds...h. Dry hands with paper towels and turn faucets off with the paper towel...2. Use single-use gloves while preparing and serving all ready-to-eat foods...whole fruits and vegetables...7. Clean and sanitize all work surface...after each task. 8. Prevent cross-contamination...c. Do not use the same cutting board for raw and cooked			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155325	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/01/2014
NAME OF PROVIDER OR SUPPLIER MEADOW VIEW HEALTH AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 ANSON ST SALEM, IN 47167	

(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
	foods...." 3. On 7/28/14 at 2:10 p.m., the temperature in the walk-in refrigerator was 46 degrees F. Dietary staff indicated they had not been in it for 30 minutes. On 7/28/14 at 2:32 p.m., the Dietary Manager indicated no one had complained about the milk being spoiled. 3.1-21(i)(1)			
F000431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155325	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/01/2014
NAME OF PROVIDER OR SUPPLIER MEADOW VIEW HEALTH AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 ANSON ST SALEM, IN 47167	

(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
	the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure medications were stored and/or labeled properly. This deficient practice affected 1 of 2 medication rooms and 2 of 4 medication carts observed. (Resident #135 and Resident #9) Findings include: 1. On 7/29/14 at 2:43p.m., the medication cart on the Annex unit was observed unlocked with no nurse. On 7/29/14 at 2:44p.m., RN #1 indicated "I know my cart was not locked. It should be locked at all times unless I am right there." 2. On 7/29/14 at 3:14p.m., the medication room on the Annex Unit was	F000431	The unlocked med cart was locked and secured. The vial of Humalog Insulin was disposed of per facility policy and procedure. The identified medication had a change of direction label put in place per facility policy and procedure. A 100% audit will be conducted to ensure that medication labels and the MAR match. Licensed staff will be in-serviced on Medication Pass and Medication storage Policy and Procedure. It is the responsibility of the Licensed Nurses to secure, store and pass medications as per expectation. A Med Pass audit will be conducted by DON/designee, 5 times per week for 4 weeks, 1 time per week for 5 months, and Monthly for 6 months. Any issue identified will be immediately corrected, 1:1 re-education completed. Any	08/31/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155325	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/01/2014
NAME OF PROVIDER OR SUPPLIER MEADOW VIEW HEALTH AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 ANSON ST SALEM, IN 47167	

(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
	observed to have an opened vial of Humalog Insulin, a medication used to lower blood glucose levels, stored in the refrigerator belonging to Resident #135. The vial did not have a date recorded of when it was opened. On 7/29/14 at 3:17p.m., RN#1 indicated she was not sure how the insulin should be stored. On 7/29/14 at 3:24p.m., Unit Manager #1 indicated, " We have not used this vial. It was not opened here. The family brought it in and the nurse put it in the refrigerator." When asked how the medication should be stored she indicated, "Once the insulin is opened it should be stored on the cart." 3. On 7/29/14 at 2:33p.m., the medication cart on the North Unit was observed. A medication belonging to Resident # 9 had a label on the box that read, Depakote, a medication used to treat seizures, 500 milligrams twice a day. The Medication Administration Record [MAR] read Depakote 500 milligrams three times a day. On 7/29/14 at 2:35p.m., LPN #1 verified the physician's order in the clinical record and then notified the pharmacy. He indicated the pharmacy had not delivered		further identification of non compliance will result in disciplinary action, up to and including termination. The ADM/designee will be responsible to review completed audits as per the identified schedule. Audit results will be presented to the QAPI committee monthly for 12 months. Any further action will be as determined by the QPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155325	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2014
NAME OF PROVIDER OR SUPPLIER MEADOW VIEW HEALTH AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 ANSON ST SALEM, IN 47167	

(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
	the medication as ordered on 7/25/14 due to a billing issue. LPN #1 indicated, the nurse should have put a change of direction label on the box until the correct dose came from the pharmacy. He indicated there was no change of direction label on the box. A copy of the policy titled, "Storage and Expiration of Medications, Biologicals, Syringes and Needles," was provided by the Director of Nursing on 7/29/14 at 4:42p.m. The policy indicated, "Facility should ensure that all medications...are securely stored in a locked cabinet/cart...once a medication is opened, facility should follow manufacturer guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened...." 3.1-25 (m) 3.1-25 (o)			
F000456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155325	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW VIEW HEALTH AND REHABILITATION CENTE	900 ANSON ST SALEM, IN 47167

(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
	The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation, interview and record review, the facility failed maintain the walk-in refrigerator at a temperature below 41 degrees Fahrenheit. The deficient practice had the potential to effect 79 of 81 patients served milk. Findings include: On 7/27/14 at 2:50 p.m., the thermometer cover on the outside of the walk-in refrigerator was cracked. Cook #2 indicated the outside thermometer did not work. On 7/27/14 at 2:51 p.m., the walk-in refrigerator had a moderate amount of dust on the ceiling directly above the condenser fan. On 7/27/14 at 2:51 p.m., the condenser fan had a moderate amount of dust swaying up and down with the air circulation. On 7//28/14 at 1:15 p.m., Cook #1 indicated the Assistant Dietary Manager had placed a new thermometer in the walk-in refrigerator. On 7/28/14 at 1:40 p.m., review of the refrigeration temperature log indicated	F000456	The thermometer has been removed from the outside of the walk-in cooler. 3 new refrigerator thermometers have been installed in the walk-in cooler. Milk that was in the cooler during the survey process was disposed of and replaced. The facility also had a contractor inspect the cooler. Dietary and Maintenance Staff will be in-serviced on facilities temperature monitoring and recording policy and procedure. The Maintenance Director/designee will be responsible to monitor the walk-in cooler temps of all 3 new thermometers will be recorded 3 times per day for 4 weeks, 1 times per week for 5 months, and monthly times 6 months. Any issue identified will be immediately corrected, 1:1 re-education completed. Any further identification of non compliance will result in disciplinary action, up to and including termination. The ADM/designee will be responsible to review completed audits as per the identified schedule. Audit results will be reviewed and discussed with QPI committee monthly times 12 months. Any further action will be as determined by the QPI committee	08/31/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155325	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2014
NAME OF PROVIDER OR SUPPLIER MEADOW VIEW HEALTH AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 ANSON ST SALEM, IN 47167	

(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
	the walk-in temperatures were checked twice a day, and between July 1, 2014 through July 24, 2014, temperatures ranged from 30 degrees to 39 degrees Fahrenheit (F). During an interview the Director of Maintenance, also present in the kitchen on 7/28/14 at 1:40 p.m., indicated he had been periodically monitoring the walk- in cooler as he was waiting on a new door he ordered since the old one had rusted out at the top and was not sealing. On 7/28/14 at 2:10 p.m., the temperature in the walk-in refrigerator was 46 degrees F. Dietary staff indicated they had not been in it for 30 minutes. On 7/28/14 at 2:32 p.m., the Dietary Manager indicated no one had complained about the milk being spoiled On 7/28/14 at 2:28 p.m., the Administrator indicated there was a contractor on the way. He also indicated they were going to discard all the cartons of milk to be on the safe side and have new delivered in the morning. On 7/29/14 at 8:45 a.m., the Administrator indicated the contractor could not find anything wrong with the refrigerator. He also indicated the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155325	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/01/2014
NAME OF PROVIDER OR SUPPLIER MEADOW VIEW HEALTH AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 ANSON ST SALEM, IN 47167	

(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
	contractor cleansed the refrigerator coils. On 7/29/14 at 10:00 a.m., the Administrator provided a copy of the invoice from the contractor. It included, but was not limited to the following: "Problem: Walk-in cooler down. Description: 07/28/14--Cooler not holding temp (temperature) door gasket has pulled away from door and foam insert has pulled loose not holding trim for gasket to hold has to be changed in door will call supplier and have made." On 7/30/14 at 1:30 p.m., the Director of Maintenance presented a copy of his Preventative Maintenance logs. Review of these logs at this time, failed to list the walk-in cooler as being a part of his equipment he maintained on a regular basis. During an interview at this time with the Director of Maintenance, he indicated that he did not personally take the cooler temperatures as he would get them from dietary and then marked them in his log book. 3.1-19(bb)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155325	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW VIEW HEALTH AND REHABILITATION CENTE	900 ANSON ST SALEM, IN 47167

(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