

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155428	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  11/14/2012
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NAME OF PROVIDER OR SUPPLIER  MERIDIAN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2102 S MERIDIAN ST INDIANAPOLIS, IN 46225
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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: 11/14/12</p> <p>Facility Number: 000386 Provider Number: 155428 AIM Number: 100286820</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Meridian Nursing and Rehabilitation Center 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 II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has battery operated</p>	K0000	<p><b>Submission of this plan of correction does not constitute an admission by Meridian Nursing and Rehabilitation Center or its' management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</b> On 11/14/12 a life safety surveyor from the Indiana State Department of Health completed a life safety survey at Meridian Nursing and Rehabilitation. Please consider this plan of correction to be the facility's credible allegation of compliance. as of 12/14/12. Respectfully submitted Tiffany M Ross Administrator Meridian Nursing and Rehabilitation</p>	
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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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	<p>smoke detectors in all resident sleeping rooms. The facility has a capacity of 44 and had a census of 26 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except two storage sheds constructed of wood which were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/20/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0047 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 Based on observation and interview, the facility failed to ensure 1 of 6 exit signs with battery backup illuminated when the backup battery test button was pushed. This deficient practice could affect 10 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Director during a tour of the facility from 10:55 a.m. to 12:15 p.m. on 11/14/12, the exit sign in the corridor by Room 5 failed to illuminate when the backup battery test button for the exit sign was pushed five times. Based on interview at the time of observation, the Environmental Director acknowledged the exit sign in the corridor by Room 5 failed to illuminate when the backup battery test button was pushed.</p> <p>3.1-19(b)</p>	K0047	<p><b>K047 Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system.</b></p> <p>A Non-functioning batteries were replaced</p> <p>B No other residents were affected or identified as being affected</p> <p>C The Environmental Director was in-serviced on the importance of maintaining working batteries in all exit lights</p> <p>D Environmental Director or Designee will audit exit light batteries will be checked 1 time per week times 3 months, checking the exit lights will be a part of preventative maintenance.</p>	12/14/2012	

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			Results of all audits will be presented to the facility's quality assurance committee review for additional recommendations if necessary.  Date of completion Dec 14, 2012		

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K0050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to document fire drills conducted on the third shift for 1 of 4 quarters. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Disaster/Fire Drill Record" documentation with the Environmental Director during record review from 9:20 a.m. to 10:55 a.m. on 11/14/12, documentation of a fire drill conducted on the third shift for the third quarter of 2012 was not available for review. Based on interview at the time of record review, the Environmental Director acknowledged documentation of a fire drill conducted on the third shift for the third quarter of 2012 was not available for review.</p> <p>3.1-19(b)</p>	K0050	<p><b>K050</b></p> <p><b>Fire Drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of an established routine. Responsibility for planning and conducting drills is assigned to competent persons who are qualified to exercise leadership. Where drills are conducted between 9PM and 6AM a coded announcement may be used instead of audible alarms.</b></p> <p>A A third shift fire drill was held on Nov 29<sup>th</sup> at 5:30AM the facility's 3<sup>rd</sup> shift.</p>	12/14/2012	

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			<p>B All residents in the facility have the potential to be affected but none were identified.</p> <p>C The Environmental Director was in serviced on the frequency required by regulation of fire drills.</p> <p>D The Environmental Director or designee will hold a random fire drill on each shift each month times 3 months and then quarterly on each shift ongoing and retain documentation for review at request. The Administrator will review fire drill logs monthly times 3 months and then quarterly times 2 quarters. Results of all audits will be presented to the facility's quality assurance committee review for additional recommendations if necessary.</p> <p>-</p> <p>Date if Completion Dec 14, 2012</p>		

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K0052 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 1-5.2.5.2 states connections to the light and power service shall be on a dedicated branch circuit(s). Circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. The location of the circuit disconnecting means shall be permanently identified at the fire alarm control unit. NFPA 72, 1-5.2.5.3 states an overcurrent protective device of suitable current carrying capacity and capable of interrupting the maximum short circuit current to which it may be subject shall be provided in each ungrounded conductor. The overcurrent protective device shall be enclosed in a locked or sealed cabinet located immediately adjacent to the point of connection to the light and power conductors. This deficient practice could affect all residents, staff and visitors.</p>	K0052	<p><b>K052 A Fire Alarm System required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72.</b></p> <p>A Safe Care was at the facility on 11/30/12 to locate and mark the breaker assigned to the alarm system</p> <p>B all residents have the potential to be affected but none were identified</p> <p>C Environmental Director and all Staff will be in-serviced on location of breaker to be known in the event of an emergency with the understanding that only authorized personnel will be able</p>	12/14/2012	

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	<p>Findings include:</p> <p>Based on observation with the Environmental Director during the tour of the facility from 10:55 a.m. to 12:15 p.m. on 11/14/12, the fire alarm system breaker could not be identified or located. Based on interview at the time of observation, the Environmental Director acknowledged the fire alarm system breaker could not be identified or located.</p> <p>3.1-19(b)</p>		<p>to enter the box of the breaker.</p> <p>D the FIRE ALARM CONTROL UNIT has been marked with a red marker identifying the breaker</p> <p>-</p> <p>Completion Date Dec 14, 2012</p>		

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K0072 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Based on observation and interview, the facility failed to ensure 1 of 3 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect 20 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Director during a tour of the facility from 10:55 a.m. to 12:15 p.m. on 11/14/12, the exit discharge ramp from the outside patio at the rear exit of the building by Room 8 was barricaded with four boards and was impassable. Based on interview at the time of observation, the Environmental Director stated a vehicle had backed into the handrail for the ramp which broke the handrail and acknowledged the exit discharge ramp at the rear exit of the building by Room 8 was impassable</p> <p>3.1-19(b)</p>	K0072	<p><b>K072 Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits.</b></p> <p>A exit ramp will became accessible by removing the blockage</p> <p>B all residents have the potential to be affected but none were identified</p> <p>C Environmental Director was in serviced on definition of egress and importance of ensuring all means of egress are clear for safety. All staff will be in serviced on importance of ensuring means of egress remain free of</p>	12/14/2012	

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			<p>obstructions and impediments.</p> <p>D Environmental Director or Designee will complete walking rounds of facility interior and exterior to ensure all means of egress are clear daily as part of part of daily rounds ongoing. Results of all audits will be presented to the facility's quality assurance committee review for additional recommendations if necessary.</p> <p>-</p> <p>Completion Date Dec 14, 2012</p>		

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K0144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on record review and interview, the facility failed to ensure a monthly load test for the emergency generator was conducted for 12 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum</p>	K0144	<p><b>K144Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1</b></p> <p>A what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Weekly generator tests will continue an annual load bank test has been scheduled with Safe Care for 12/3/12. Weekly generator test for Nov 2012 were 11/16/12, 11/23/12, 11/28/12</p> <p>B all residents have the potential to be affected none were identified</p> <p>C Environmental Director has been in-serviced on proper procedure of weekly generator testing and documentation of these tests and scheduling of annual load testing.</p>	12/14/2012

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	<p>exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Weekly Generator System Service &amp; Testing" documentation with the Environmental Director during record review from 9:20 a.m. to 10:55 a.m. on 11/14/12, documentation of emergency generator load testing for July and August 2012 was not available for review. In addition, monthly load testing documentation for November 2011 through June 2012 and September and October 2012 was left blank or stated "yes" in response to "% of load". Based on interview at the time of record review, the Environmental Director acknowledged documentation of emergency generator load testing for July and August 2012 was not available for review and acknowledged monthly load testing documentation for the aforementioned period did not state the load percent rating for each monthly load test or the loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p>		<p>D Each week the Environmental Director will run a generator load test and the Administrator will sign off on the load test for 1 month. Generator load tests will be ongoing with completed documentation. Annual load bank tests will continue annually. Results of all audits will be presented to the facility's quality assurance committee review for additional recommendations if necessary.</p> <p>-</p> <p>Completion Date Dec 14, 2012</p>				

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	<p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure a complete written record of weekly inspections of the starting batteries for the emergency generator was maintained for 8 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Weekly Generator System Service &amp; Testing" documentation with the Environmental</p>			

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	<p>Director during record review from 9:20 a.m. to 10:55 a.m. on 11/14/12, documentation of emergency generator starting battery inspection records for the eight week period of July 2012 through August 2012 for the emergency generator was not available for review. Based on interview at the time of record review, the Environmental Director acknowledged documentation of emergency generator starting battery inspection records for the aforementioned eight week period was not available for review.</p> <p>3.1-19(b)</p>			

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K9999	<p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(a) The facility must be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel, and the public.</p> <p>This State Rule has not been met as evidenced by: Based on record review, observation and interview; the facility failed to implement and maintain a preventive maintenance program for battery operated smoke detectors installed in 20 of 20 resident sleeping rooms. This deficient practice could affect 26 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Battery Check Smoke Detector" documentation with the Environmental Director during record review from 9:20 a.m. to 10:55 a.m. on 11/14/12, an itemized listing of monthly battery operated smoke detector testing for each resident sleeping room location was not available for review. A monthly check of "all" battery operated smoke</p>	K9999	<p><b>K 9999 The facility must be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel, and the public.</b></p> <p>A an itemized listing of monthly battery operated smoke detector testing was implemented on 11-16-12</p> <p>B no residents had the potential to be affected as a monthly check was being conducted and documented for each room but was not itemized</p> <p>C an itemized smoke detector check is now being conducted and signed off on by the Environmental Director who has been in-serviced on the importance of making the audit tool itemized.</p> <p>D The Environmental Director will conduct itemized weekly smoke detector checks to ensure batteries in smoke detectors are operational. Results of all audits</p>	12/14/2012
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155428	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  11/14/2012
NAME OF PROVIDER OR SUPPLIER  MERIDIAN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2102 S MERIDIAN ST INDIANAPOLIS, IN 46225		
(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>detectors for October and November 2011 was entered on the aforementioned documentation. Based on observations with the Environmental Director during a tour of the facility from 10:55 a.m. to 12:15 p.m. on 11/14/12, battery operated smoke detectors were installed in all 20 resident sleeping rooms. Based on interview at the time of record review and of the observations, the Environmental Director acknowledged documentation of the periodic testing and cleaning for each battery operated smoke detector in resident sleeping rooms was not available for review.</p> <p>3.1-19(a)</p>		<p>will be presented to the facility's quality assurance committee review for additional recommendations if necessary.</p> <p>-</p> <p>Completion Date Dec 14, 2012</p>		