

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155690	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  06/09/2014
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NAME OF PROVIDER OR SUPPLIER  MEADOW BROOK REHABILITATION CENTRE & SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 1821 LINDBERG RD ANDERSON, IN 46012
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K010000	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 04/28/14 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/09/14</p> <p>Facility Number: 000027 Provider Number: 155690 AIM Number: 100266180</p> <p>Surveyor: Brett Overmyer, Life Safety Code Specialist</p> <p>At this PSR survey, Meadow Brook Rehabilitation Center &amp; Suites 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 (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors</p>	K010000		

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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K010029 SS=E	<p>and battery powered smoke detectors in the residents rooms. The facility has a capacity of 97 and had a census of 51 at the time of this visit.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/10/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 1 doors leading to hazardous areas on Hall 6 such as rooms with combustibile items was provided with self closing devices</p>	K010029	<p>·No resident were affected by the deficient practice. ·All residents that reside on the 600 Hall had the potential to be affected by the deficient practice. A self-closing device was</p>	06/24/2014

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K010062	<p>which would cause the door to automatically close and latch into the door frame. This deficient practice affects 6 residents on Hall 6 as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 06/09/14 at 02:45 p.m. with the Administrator, the paper shredder room on Hall 6 contained twenty two cardboard boxes inside the room which was greater than fifty square feet in size and did not have a self closing device on the corridor door. Based on interview on 06/09/14 at 02:45 p.m. with the Administrator, it was acknowledged the aforementioned door leading into the paper shredder room containing combustible items was not equipped with a self closing device on the door. Administrator stated that the Maintenance Manager had quit two days prior to this survey.</p> <p>This deficiency was cited on 04/28/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p> <p>NFPA 101</p>		<p>installed on storage area, to ensure that the door will automatically close.</p> <p>·The self-closing device was installed and will remain in place to ensure the automatic closure of the door to the storage area. The Administrator or designee will monitor all doors requiring a self-closure are in place and are working properly during monthly Preventative Maintenance monitoring. Any negative findings during monitoring will be corrected immediately.</p> <p>·Resultsof the Monitoring will be reviewed during the facility's quarterly QualityAssurance meeting for continued compliance, monitoring will be ongoing.</p>				

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SS=F	<p><b>LIFE SAFETY CODE STANDARD</b> Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 automatic sprinkler systems was maintained in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems. NFPA 13, 6-1.1.5 requires sprinkler piping or hangers shall not be used to support nonsystem components. This deficient practice could affect all residents as well as visitors and staff should the sprinkler pipe break and require repair.</p> <p>Findings include:</p> <p>Based on observation on 06/09/14 at 03:00 p.m. with the Administrator, a four inch diameter steel sprinkler pipe located in the riser room on Hall 4 was used to support two, one inch diameter plastic water lines which were nonsprinkler system components and a two inch diameter sprinkler pipe was used to support a 1/2" copper water pipe. Based on interview on 06/09/14 concurrent with the observation with the Administrator, it was acknowledged the aforementioned sprinkler pipes were used to support nonsprinkler components.</p>	K010062	<p>·No residents were affected by the deficient practice. The one inch plastic waterlines were removed.</p> <p>· All residents have the potential to beaffected by the deficient practice. The one inch plastic water lines were removed.</p> <p>·The facility has removed all non-system sprinkler components from the sprinklersystem. The Administrator or designee will visually inspection the sprinkler system to ensure it is not supporting non-system components during monthly Preventative Maintenance monitoring. Any negative findings during monitoring will be corrected immediately.</p> <p>·Results of the Monitoring will be reviewed during the facility's quarterly Quality Assurance meeting for continued compliance, monitoring will be ongoing.</p>	06/24/2014			

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