

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 09/03/2015
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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: 09/03/15</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 except the Annex Hall porch overhang and kitchen walk in freezer. 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</p>	K 0000	<p>The creation and submission of this plan does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation</p> <p>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 Survey Revisit on or after 10/3/2015</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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K 0025 SS=E Bldg. 01	<p>sleeping rooms. The facility has a capacity of 98 and had a census of 76 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled except the Annex Hall outside porch overhang and all areas providing facility services were sprinkled except the kitchen walk in freezer. The facility has two detached wooden storage sheds which were not sprinkled.</p> <p>Quality Review completed 09/10/15 - DA</p> <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 observations and interview, the facility failed to ensure the smoke barriers in 1 of 1 ceiling smoke barriers was constructed to provide at least a one half hour fire resistance rating. This deficient practice could affect 62 residents who use the main dining room, 18 residents who reside on the Annex</p>	K 0025	<p>1 The attic accesses identified during the survey were replaced and now included fire rated material</p> <p>2 All accesses were observed and were adjusted to include fire rated material</p> <p>3 The maintenance staff were in serviced by the Executive Director on NFPA 19 3 7 5, 19 1 6</p>	10/03/2015

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	<p>Hall, 14 residents who reside on the North Hall and 8 residents who use the therapy room.</p> <p>Findings include:</p> <p>Based on observations with the administrator and maintenance supervisor during a tour of the facility on 09/03/15 from 10:10 a.m. to 2:30 p.m., the following attic access panels were constructed on plywood; The therapy room attic access panel, the Annex Hall attic access panel near the ice room, the dining room attic access panel, the Employee Entrance Hall attic access panel, the North Hall attic access panel. Based on an interview with the maintenance supervisor on 09/03/15 at 11:40 a.m., the attic access panels throughout the facility are plywood and are a non rated material. The non rated ceiling plywood therapy room attic access panel, Annex Hall attic access panel, the dining room attic access panel, the Employee Entrance Hall attic access panel, and North Hall attic access panel were verified by the administrator and maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 09/03/15 at 2:15 p.m.</p> <p>3.1-19(b)</p>		<p>3, and 19 1 6 4</p> <p>4 The maintenance supervisor and/or designee will conduct environmental rounds to ensure all accesses are made of fire rated material weekly times 8 weeks and monthly times 10 months The results will be submitted to the CQI committee for review and any further actions will be determined</p>				

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K 0027 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 7 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires that doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect 62 residents who use the main dining room.</p> <p>Findings include:</p> <p>Based on observation on 09/03/15 at 12:20 p.m. with the administrator and maintenance supervisor, the north dining room set of smoke barrier doors had a</p>	K 0027	<p>1 The door identified during survey was adjusted to restrict the movement of smoke through it 2 All smoke barriers were observed and no further issues were identified 3 The maintenance staff were in serviced by the Executive Director on NFPA 7 2 1 4, 19 2 2 2 6, 19 3 7 5, 19 3 7 6 and 19 3 7 7 4 The maintenance supervisor and/or designee will conduct environmental rounds weekly times 8 weeks and monthly times 10 months to ensure all smoke barriers are compliant Results of the audit will be submitted to the CQI committee monthly and any further action will be determined</p>	10/03/2015
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K 0029 SS=E Bldg. 01	<p>one inch gap along the center where the doors came together in the closed position. This was verified by the administrator at the time of observation and acknowledged by the administrator at the exit conference on 09/03/15 at 2:15 p.m.</p> <p>3.1-19(b)</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</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 12 hazardous areas, such as a combustibile storage room over 100 square feet, was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 18 residents who reside on the Annex Hall.</p> <p>Findings include:</p>	K 0029	<p>1 The self closing device was added to the door identified during the survey</p> <p>2 All doors were reviewed to ensure that any requiring a self closing device had one in place and no further issues were noted</p> <p>3 The maintenance staff were in serviced by the Executive Director on NFPA 19 3 5 4 and 19 3 2 1</p> <p>4 The maintenance supervisor an/or designee will conduct environmental rounds weekly times 8 weeks and monthly times</p>	10/03/2015

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K 0056 SS=E Bldg. 01	<p>Based on observations on 09/03/15 at 12:50 p.m. with the administrator and maintenance supervisor, the Annex Hall storage room, which measured one hundred ten square feet and had six shelves of combustible cardboard boxes of dietary dry storage, had a door lacking a self closing device. This was verified by the administrator and maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 09/03/15 at 2:15 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 kitchen walk in freezer was provided with sprinkler coverage. This deficient</p>	K 0056	<p>10 months to ensure all doors that require a self closer has one installed The results of the audit will be submitted to the CQI committee monthly for review and any further action determined</p> <p>1 The area's identified during survey will have sprinkler heads installed 2 Environmental rounds were conducted and no other areas were found to need a sprinkler</p>	10/03/2015

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	<p>practice could affect 62 residents who use the main dining room.</p> <p>Findings include:</p> <p>Based on observation on 09/03/15 at 1:10 p.m. with the administrator and maintenance supervisor, the kitchen walk in freezer was not provided with sprinkler coverage. This was verified by the administrator and maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 09/03/15 at 2:15 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 combustible overhang porch exceeding four feet was provided with sprinkler coverage. NFPA 13, 5-13.8.1 requires sprinklers shall be installed under exterior combustible roofs or canopies exceeding four feet in width. This deficient practice affects 18 residents who reside on the Annex Hall and would use the Annex Hall exit during an evacuation.</p> <p>Findings include:</p> <p>Based on observation on 09/03/15 at 12:40 p.m. with the administrator and</p>		<p>installed at this time</p> <p>3 The maintenance staff were in serviced on NFPLA 19 3 5 and 13, 5-13 8 1</p> <p>4 The maintenance supervisor and/or designee will conduct environmental rounds to ensure all areas that require a sprinkler has one weekly times 8 weeks and monthly times 10 months The results will be submitted to the CQI committee monthly and any further action determined</p>				

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K 0062 SS=F Bldg. 01	<p>maintenance supervisor, the Annex Hall outside front porch overhang, which measured five feet eight inches by thirty six feet, was not provided with sprinkler coverage. Based on observation of the porch construction with the maintenance supervisor and interview on 09/03/15 at 12:55 p.m., it was stated the porch is constructed of wooden rafters and plywood siding and does not have a fire separation where the porch is constructed onto the facility. This was acknowledged by the administrator at the exit conference on 09/03/15 at 2:15 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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 record review and interview, the facility failed to ensure a complete flushing program was conducted after an obstruction investigation was conducted on 1 of 1 automatic dry sprinkler piping system which indicated the presence of scale and silt buildup in the sprinkler piping. NFPA 25, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems,</p>	K 0062	<p>1 The flush identified during the survey has been scheduled to be completed</p> <p>2 The flush identified during the survey has been scheduled to be completed</p> <p>3 The maintenance staff were in serviced on NFPA 19 7 6, 4 6 12, 13 and 25 9 7 5</p> <p>4 The maintenance supervisor and or designee will conduct monthly audits time 12 months to</p>	10/03/2015

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	<p>10-2.3 requires if an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the administrator on 09/03/15 at 10:10 a.m., the most recent sprinkler system internal pipe inspection from Vanguard Alarm Services was dated 08/27/14. Furthermore, the results of the inspection indicated "the system has rust and debris buildup. Recommend a complete flush". Based on an interview with the administrator on 09/03/15 at 10:40 a.m., when asked if the sprinkler system flushing was conducted as a follow up action to the internal pipe inspection report dated 08/27/14, the administrator stated the facility acquired a quote from Vanguard Alarm Services and provided a copy of the quote for a sprinkler system flush dated 08/12/15. Furthermore, the administrator indicated the quote was sent to the facility corporate office and the quote has yet to be approved.</p>		ensure that sprinkler maintenance was preformed as scheduled Results of this audit will be submitted to the CQI committee for review and further actions determined	

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	The lack of recommended follow up action taken after the internal pipe inspection of the sprinkler system was verified by the administrator at the time of record review and interview and acknowledged by the administrator at the exit conference on 09/03/15 at 2:15 p.m. 3.1-19(b)				