PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) I			DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLET.		ETED		
		155428	B. W	NG		08/10/	2020
				CTREET	ADDRESS SITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
		25.145.11.17.47.01.1.05.17.55			MERIDIAN ST		
MERIDIA	N NURSING AND I	REHABILITATION CENTER		INDIAN	IAPOLIS, IN 46225		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROWING BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	16	DATE
E 0000							
Bldg							
g.	An Emergency Prer	paredness Survey was	E 00	000	Please accept the following pl	an	
		diana State Department of		<i>7</i> 00	of correction for Meridian Nurs		
	-	the with 42 CFR 483.73.			and Rehab.	,,,,,,	
	ricaitii iii accordanc	c with 42 C1 K 403.73.			and renab.		
	Survey Date: 08/10)/20					
	Facility Number: 0						
	Provider Number:						
	AIM Number: 1002	286820					
	At this Emergency 1	Preparedness survey,					
		nd Rehabilitation Center was					
		compliance with Emergency					
		rements for Medicare and					
		ing Providers and Suppliers,					
	42 CFR 483.73.	ing Froviders and Suppliers,					
	42 CFK 403.73.						
	The facility has 44 o	certified beds. At the time of					
	the survey, the cens						
	the sairey, the cons	us (145 20.					
	Quality Review con	npleted on 08/12/20					
		42 CFR Subpart 483.73 is					
	NOT MET as evide	nced by:					
E 000 t	100 740/ > 115 -	4() 440 440()					
E 0004	403.748(a), 416.54						
SS=C	441.184(a), 482.1						
Bldg	483.73(a), 484.10	2(a), 485.625(a),					
	485.68(a), 485.72						
	486.360(a), 491.12	2(a), 494.62(a)					
	Develop EP Plan,	Review and Update					
	Annually						
	The [facility] must	comply with all applicable					
	Federal, State and						
		uirements. The [facility]					
		blish and maintain a					
	· · · · · · · · · · · · · · · · · · ·	nergency preparedness					
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURI		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.

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION	COMPLETED	
	155428	B. WING		08/10/2020	
	PROVIDER OR SUPPLIER AN NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES	2102 S	ADDRESS, CITY, STATE, ZIP CODE MERIDIAN ST IAPOLIS, IN 46225	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
	program that meets the requirements of this section.				
	The emergency preparedness program must include, but not be limited to, the following elements:				
	(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:				
	* [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.				
	* [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually.				
	* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was reviewed	E 0004	E004	08/25/2020	
	and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants.		What corrective Action will accomplished for those reside		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

254R21

Facility ID: 000386

If continuation sheet

Page 2 of 37

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPL	
		155428	B. WING		. 08/10	/2020
NAME OF D	ROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP COI	DE	
NAME OF P	KO VIDEK OK SUPPLIER		2102 9	S MERIDIAN ST		
MERIDIA	N NURSING AND F	REHABILITATION CENTER	INDIA	NAPOLIS, IN 46225		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO)	CTION ULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	PROPRIATE	DATE
	Findings include:			found to have been affect the alleged deficient practice.	•	
	Based on review of Planning & Resource dated February 2014 Emergency Manage dated 01/14/19 with during record review a.m. on 08/10/20, does emergency program within the most record available for review plans were not dated recent twelve month at the time of record Director stated she to its emergency program and updated within emergency program	"Emergency Preparedness the Manual" documentation 4 and "Comprehensive thement Plan" documentation the Regional Director to from 9:40 a.m. to 11:00 tocumentation for a complete the reviewed by the facility tent twelve month period was triew. The aforementioned did as reviewed within the most the period. Based on interview direview, the Regional thought the facility has had thredness program reviewed the last year but agreed the the documentation was not trithin the most recent twelve		The EP Plan was update reviewed at the 8/25/202 meeting. The updated p added to the EP Plan Bit. 2. How will other reside the same potential to affithe alleged deficient practice action will be taken? No residents were affect alleged deficient practice residents had the potent affected. 3. What measures will be place or systemic change made to ensure that the deficient practice does not be a systemic does not be plan has been added to Calendar for January of year.	ed and 20 QAPI plan was inder. Ints having fected by citice be ective externed by the extinct of the EP the QAPI every	
				4. How will the corrective be monitored to ensure to		

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

	OF OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155428	X2) MULTIPLE CONSTRUCTION (X A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/10/2020	
	PROVIDER OR SUPPLIE	REHABILITATION CENTER	2102 S	ADDRESS, CITY, STATE, ZIP CODE MERIDIAN ST JAPOLIS, IN 46225	ı	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
				alleged deficient practice will occur?	not	
				QAPI calendars are reviewed monthly the QAPI committee overseen by the administrator reviewed by corporate risk management. If threshold of 100% is not achieved an actic plan will be developed to ensucompliance.	r and	
				5. By what date will systemic changes be completed? 8/25/2020		
				0/20/2020		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

254R21

Facility ID: 000386

If continuation sheet

Page 4 of 37

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155428		A. BUILDING B. WING	NSTRUCTION	СОМ	E SURVEY PLETED 0/2020
	PROVIDER OR SUPPLIER AN NURSING AND REHABILITATION CENTER	2102 S N	DDRESS, CITY, STATE, ZIP COD MERIDIAN ST APOLIS, IN 46225	E	
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
E 0006 SS=C Bldg	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. *[For LTC facilities at §483.73(a)(1):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

254R21

Facility ID: 000386

If continuation sheet

Page 5 of 37

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155428	A. BUILDING B. WING		COMPLETED 08/10/2020	
	ROVIDER OR SUPPLIER N NURSING AND F	REHABILITATION CENTER	2102 S	ADDRESS, CITY, STATE, ZIP CODE MERIDIAN ST APOLIS, IN 46225		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
	and maintain an elplan that must be least every 2 years following: (1) Be based on all facility-based and assessment, utilizing approach, including (2) Include strategemergency events assessment. * [For Hospices at Emergency Plan. and maintain an elplan that must be least every 2 years following: (1) Be based on all facility-based and assessment, utilizing approach. (2) Include strategemergency events assessment, include the consequences disasters, and other affect the hospice. Based on record reverse facility failed to main preparedness plan the includes a document community-based right all-hazards approach.	The ICF/IID must develop mergency preparedness reviewed, and updated at s. The plan must do the and include a documented, community-based risk ng an all-hazards g missing clients. ies for addressing identified by the risk §418.113(a)(2):] The Hospice must develop mergency preparedness reviewed, and updated at s. The plan must do the and include a documented, community-based risk ng an all-hazards ies for addressing identified by the risk ding the management of of power failures, natural er emergencies that would is ability to provide care. iew and interview, the intain an emergency nat was (1) based on and ted, facility-based and sk assessment, utilizing an in, including missing residents	E 0006	E006 1.What corrective Action will accomplished for those resider found to have been affected by the alleged deficient practice?	nts	
	emergency events ic			The Facility Annual Hazard Assessment was updated and		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

254R21

Facility ID: 000386

If continuation sheet Page 6 of 37

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155428	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/10/2020
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	2102	T ADDRESS, CITY, STATE, ZIP CODE S MERIDIAN ST NAPOLIS, IN 46225	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	deficient practice co	2 CFR 483.73(a) (2). This buld affect all occupants.		reviewed at the 8/25/2020 QA meeting. The updated assessment was added to the	
	Planning & Resourd dated February 201- Emergency Managed dated 01/14/19 with during record review a.m. on 08/10/20, a and community-bass an all-hazards approrecent twelve month review. Based on in review, the Regional documented facility risk assessment, util approach, reviewed	"Emergency Preparedness be Manual" documentation 4 and "Comprehensive ement Plan" documentation in the Regional Director of w from 9:40 a.m. to 11:00 documented facility-based ed risk assessment, utilizing each, reviewed within the most in period was not available for interview at the time of record all Director agreed a re-based and community-based lizing an all-hazards within the most recent twelve of available for review at the		Plan Binder. 1.How will other residents having the same potential to affected by the alleged deficie practice be identified and what corrective action will be taken. No residents were affected by alleged deficient practice. All residents had the potential to affected. 1.What measures will be purinto place or systemic change will be made to ensure that the alleged deficient practice does occur? The update and review of the Facility Hazard Assessment had been added to the QAPI Cale for January of every year. 1.How will the corrective act be monitored to ensure the alleged deficient practice will record. QAPI calendars are reviewed monthly the QAPI committee overseen by the administrator reviewed by corporate risk management. If threshold of 100% is not achieved an action plan will be developed to ensure compliance.	nt t ? the be t s e s not as ndar ion not

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

254R21

Facility ID: 000386

If continuation sheet

Page 7 of 37

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155428	(X2) MULTIPL A. BUILDING B. WING		NSTRUCTION	(X3) DATE : COMPL 08/10/	ETED
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	210	2 S	ADDRESS, CITY, STATE, ZIP CODE MERIDIAN ST APOLIS, IN 46225		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ζ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
E 0013 SS=C Bldg	403.748(b), 416.54441.184(b), 482.15483.73(b), 484.102485.68(b), 485.72486.360(b), 491.12Development of E	5(b), 483.475(b), 2(b), 485.625(b), 7(b), 485.920(b),			1.By what date will systemic changes be completed? 8/25/2020		
	develop and imple preparedness poli- based on the eme paragraph (a) of the assessment at par section, and the co- paragraph (c) of the	cies and procedures, rgency plan set forth in nis section, risk ragraph (a)(1) of this rommunication plan at nis section. The policies ust be reviewed and					
	and procedures. T develop and imple preparedness poli- based on the eme paragraph (a) of the assessment at para section, and the co- paragraph (c) of the	cies and procedures, rgency plan set forth in his section, risk ragraph (a)(1) of this hommunication plan at his section. The policies hust be reviewed and					
	-	ies at §494.62(b):] dures. The dialysis					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

254R21

Facility ID: 000386

If continuation sheet

Page 8 of 37

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	B. W				
		155428	D. W			08/10/	/2020
NAME OF F	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					MERIDIAN ST		
MERIDIA	N NURSING AND	REHABILITATION CENTER		INDIAN	IAPOLIS, IN 46225		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	-	op and implement					
		redness policies and					
	-	d on the emergency plan					
		aph (a) of this section, risk					
		ragraph (a)(1) of this					
		ommunication plan at					
		nis section. The policies					
	-	nust be reviewed and					
	-	very 2 years These					
	fire, equipment or	ide, but are not limited to,					
		gencies, water supply					
interruption, and natural disasters likely to							
		y's geographic area.					
		view and interview, the	E 0	013	E013		08/25/2020
		velop and implement		015			00/25/2020
	emergency prepared				1.What corrective Action wil	be	
	procedures. The po	licies and procedures must			accomplished for those reside	nts	
	be reviewed and up	dated at least annually in			found to have been affected b	у	
	accordance with 42	CFR 483.73(b). This			the alleged deficient practice?		
	deficient practice co	ould affect all occupants.					
					The EP Plan with policies and		
	Findings include:				procedures were updated and		
					reviewed at the 8/25/2020 QA		
		"Emergency Preparedness			meeting. The updated plan w	as	
	_	ce Manual" documentation 4 and "Comprehensive			added to the EP Plan Binder.		
	_	ement Plan" documentation			2. How will other residents ha	vina	
	2 , 2	the Regional Director			the same potential to affected	J	
		w from 9:40 a.m. to 11:00			the alleged deficient practice b	-	
	_	documented facility-based			identified and what corrective	,,,	
		sed risk assessment, utilizing			action will be taken?		
	-	pach, reviewed within the most					
		h period was not available for			No residents were affected by	the	
		nterview at the time of record			alleged deficient practice. All		
	review, the Regiona	al Director agreed policies			residents had the potential to	be	
		ed on a documented			affected.		
	-	ommunity-based risk					
		g an all-hazards approach,			3. What measures will be put		
	reviewed within the	e most recent twelve month			place or systemic changes wil	l be	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

254R21

Facility ID: 000386

If continuation sheet

Page 9 of 37

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155428		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/10/2020	
	PROVIDER OR SUPPLIER AN NURSING AND REHABILITATION CENTER	2102 S	ADDRESS, CITY, STATE, ZIP CODE MERIDIAN ST NAPOLIS, 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 APPROPRIA DEFICIENCY)	DATE	
	period was not available for review at the time of the survey.		made to ensure that the alleg deficient practice does not oc The update and review of the Plan with policies and proced has been added to the QAPI Calendar for January of every year. 4. How will the corrective act be monitored to ensure the alleged deficient practice will occur? QAPI calendars are reviewed monthly the QAPI committee overseen by the administrator reviewed by corporate risk management. If threshold of 100% is not achieved an actic plan will be developed to ensure the compliance. 5. By what date will systemic changes be completed?	EP ures ion not and on ure	
E 0029 SS=C Bldg	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).		8/25/2020		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

254R21

Facility ID: 000386

If continuation sheet Page 10 of 37

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155428	· /	JILDING	ONSTRUCTION	(X3) DATE COMPL 08/10 /	ETED
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		2102 S	ADDRESS, CITY, STATE, ZIP CODE MERIDIAN ST IAPOLIS, IN 46225		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	facility failed to develope emergency prepared that complies with I was reviewed and u accordance with 42 deficient practice of Findings include: Based on review of Planning & Resourd dated February 201 Emergency Managed dated 01/14/19 with during record review a.m. on 08/10/20, demergency prepared reviewed by the fact twelve month perio Based on interview the Regional Direct had an emergency previewed within the	view and interview, the velop and maintain an dness communication plan Federal, State, and local laws pdated at least annually in CFR 483.73(c). This build affect all occupants. "Emergency Preparedness are Manual" documentation 4 and "Comprehensive ement Plan" documentation at the Regional Director are from 9:40 a.m. to 11:00 occumentation for a complete dness communication plan allity within the most recent d was not available for review, at the time of record review, or agreed the facility has not preparedness program are most recent twelve month dies a communication plan.	E 00	029	1. What corrective Action will accomplished for those reside found to have been affected be the alleged deficient practice? The EP & Plan was updated a reviewed at the 8/25/2020 QA meeting. The updated plan wadded to the EP Plan Binder. 2. How will other residents had the same potential to affected the alleged deficient practice be identified and what corrective action will be taken? No residents were affected by alleged deficient practice. All residents had the potential to laffected. 3. What measures will be put place or systemic changes will made to ensure that the alleged deficient practice does not occur. The update and review of the Plan has been added to the Q Calendar for January of every year. 4. How will the corrective action be monitored to ensure the alleged deficient practice will roccur? QAPI calendars are reviewed monthly the QAPI committee.	ints y Ind PI as Iving by De the be into I be ed cur? EP API	08/25/2020

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

254R21

Facility ID: 000386

If continuation sheet

Page 11 of 37

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155428	(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/10/2020
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	2102	T ADDRESS, CITY, STATE, ZIP CODE S MERIDIAN ST NAPOLIS, IN 46225	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION DATE
E 0039 SS=C Bldg	441.184(d)(2), 482. 483.73(d)(2), 484. 485.68(d)(2), 485. 486.360(d)(2), 495. EP Testing Requir *[For RNCHI at §4 HHAs at §484.102 "Organizations" ur §485.920, RHC/F0 Facilities at §494.6 (2) Testing. The [facilities at §494.6 (2) Testing. The [facilities at §494.6 (2) Testing. The [facilities at §494.6 (3) Testing. The [facilities at §494.6 (4) Where exercises to test the annually. The [facilities at §494.6 (5) Testing. The [facilities at §494.6 (6) Testing. The [facilities at §494.6 (7) Testing. The [facilities at §494.6 (8) Testing. The [facilities at §494.6 (9) Testing. The [facilities at §494.6 (10) Testing. The [facilities at §494.6 (11) Testing. The [facilities at §494.6 (12) Testing. The [facilities at §494.6 (13) Testing. The [facilities at §494.6 (14) Testing. The [facilities at §494.6 (15) Testing. The [facilities at §494.6 (16) Testing. The [facilities at §494.6 (17) Testing. The [facilities at §494.6 (18) Testing. The [facilities at §494.6 (18) Testing. The [facilities at §494.6 (18) Testing. The [facilities at §494.6 (19) Testing. The [facilities at §494.6 (19) Testing. The [facilities at §494.6 (19) Testing. The [facilities at §494.6 (2) Testing. The [facilities at §494.6 (2) Testing. The [facilities at §494.6 (3) Testing. The [facilities at §494.6 (4) Testing. The [facilities at §494.6 (5) Testing. The [facilities at §494.6 (6) Testing. The [facilities at §494.6 (7) Testing. The [facilities at §494.6 (8) Testing. The [facilities at §494.6 (9) Testing. The [facilities at §494.6 (19) Testing. The [facilities at §494.6 (19) Testing. The [facilities at §494.6 (19) Testing. The [facilities at §494.6 (10) Testing. The [facilities at §494.6 (1	03.748, ASCs at §416.54, c, CORFs at §485.68, OPO, oder §485.727, CMHC at QHC at §491.12, ESRD 62]: acility] must conduct one emergency plan lity] must do all of the in a full-scale exercise that ed every 2 years; or a community-based cessible, conduct a tional exercise every 2 [facility] experiences an one of the emergency lity] is exempt from		overseen by the administrative reviewed by corporate risk management. If threshold of 100% is not achieved an acplan will be developed to encompliance. 5. By what date will system changes be completed? 8/25/2020	of etion nsure

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

254R21

Facility ID: 000386

If continuation sheet

Page 12 of 37

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155428			UILDING	INSTRUCTION	COMPLETED 08/10/2020		
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE 2102 S MERIDIAN ST INDIANAPOLIS, IN 46225			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E NATE	(X5) COMPLETION DATE
	functionset of the actual (ii) Conduct a least every 2 year full-scale or functing paragraph (d) conducted, that m limited to the follow (A) A sec is community-based facility-based function (B) A money (C) A tab that is led by a fact group discussion clinically-relevant a set of problem essages, or preference and a set of problem essages, or preference at least annually following: (i) Testing for how the patient's home conduct exercises at least annually following: (i) Participate that is community (A) When exercise is not accindividual facility be every 2 years.	titional exercise following the all event. In additional exercise at s, opposite the year the conal exercise under (2)(2)(i) of this section is any include, but is not wing: cond full-scale exercise that ed or individual, etional exercise; or ock disaster drill; or obletop exercise or workshop oblitator and includes a using a narrated, want emergency scenario, em statements, directed pared questions challenge an emergency yze the [facility's] response occumentation of all drills, and emergency evise the [facility's] as needed. 418.113(d):] spices that provide care in each to test the emergency plan. The hospice must do the en in a full-scale exercise based every 2 years; or a community based dessible, conduct an obased functional exercise					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

254R21

Facility ID: 000386

If continuation sheet

Page 13 of 37

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155428	A. BUILDING B. WING		COMPLETED 08/10/2020		
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
MERIDIA	N NURSING AND F	REHABILITATION CENTER			MERIDIAN ST APOLIS, IN 46225		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		of the emergency plan,					
	· ·	s exempt from engaging in ill scale community-based					
	exercise or individ						
		e following the onset of the					
	emergency event.	_					
		an additional exercise every					
	* *	the year the full-scale or					
		e under paragraph (d) (2)					
		s conducted, that may					
	include, but is not	limited to the following:					
	(A) A se	cond full-scale exercise that					
		ed or a facility based					
	functional exercise						
		ock disaster drill; or					
		oletop exercise or workshop					
		ilitator and includes a					
	group discussion t	-					
	-	vant emergency scenario,					
	messages, or prep	em statements, directed					
		hallenge an emergency					
	plan.	mailetige air efficigeticy					
		pices that provide inpatient					
		hospice must conduct					
		ne emergency plan twice					
		pice must do the following:					
		in an annual full-scale mmunity-based; or					
		n a community-based					
	` '	cessible, conduct an					
		acility-based functional					
	exercise;	-					
	· ·	hospice experiences a					
		ide emergency that					
		of the emergency plan,					
	the hospice i	s exempt from engaging in					
	· ·	ıll-scale community based					
	or facility-based fu	nctional					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

254R21

Facility ID: 000386

If continuation sheet

Page 14 of 37

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

i i		ì		ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING		COMPL	
		155428	B. W	ING		08/10/	/2020
(F. 0.F. n			-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF F	PROVIDER OR SUPPLIEF	R.		2102 S	MERIDIAN ST		
MERIDIA	N NURSING AND	REHABILITATION CENTER		INDIAN	APOLIS, IN 46225		
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES	ı	ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG TAG TAG TAG TAG TAG TAG TAG		ATE	DATE
1710		wing the onset of the		1710			DATE
	emergency event.	-					
		an additional annual					
	·	include, but is not limited					
	to the following:	molade, but is not innited					
	_	cond full-scale exercise that					
		ed or a facility based					
	functional exercise						
		ock disaster drill; or					
	· '	bletop exercise or workshop					
	, ,	that includes a group					
	discussion using a						
	_	vant emergency scenario,					
	1	em statements, directed					
	messages, or pre	pared questions					
	designed to d	hallenge an emergency					
	plan.						
	(iii) Analyze t	the hospice's response to					
	and maintain docu	umentation of all drills,					
	tabletop exercises	s, and emergency events					
	and revise the	e hospice's emergency					
	plan, as needed.						
	l						
		141.184(d), Hospitals at					
	§482.15(d), CAHs	. , ,					
	` ' -	PRTF, Hospital, CAH] must					
		to test the emergency plan					
		ne [PRTF, Hospital, CAH]					
	must do the follow	e in an annual full-scale					
		ommunity-based; or					
		n a community-based					
		cessible, conduct an					
		facility-based functional					
	exercise	-					
		[PRTF, Hospital, CAH]					
	1	ctual natural or man-made					
		equires activation of					
		cy plan, the [facility] is					
		aging in its next required					
		J J					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

254R21

Facility ID: 000386

If continuation sheet

Page 15 of 37

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUII		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMPI	(X3) DATE SURVEY COMPLETED 08/10/2020	
	F PROVIDER OR SUPPLIEF	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2102 S MERIDIAN ST INDIANAPOLIS, IN 46225				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE	
	exercise following emergency event. (ii) Conduct a exercise or and the limited to the following (A) A see is community-base facility-based function (B) A monomorphism (C) A table that is led by a fact group discussion, clinically-releverant as et of problem essages, or predesigned to oplan. (iii) Analyze the and maintain document table to exercise and revise the plan, as needed. *[For LTC Facilities (2) The [LTC facilities (3) The emergence facility, ICF/IID] monomorphism (i) Participate exercise that is considered annual individual, exercise (B) If the experiences an according to the service of the services and according to the services and the	cility-based functional the onset of the in [additional] annual lat may include, but is not wing: cond full-scale exercise that ed or individual, a ctional exercise; or lock disaster drill; or loletop exercise or workshop cilitator and includes a lusing a narrated, want emergency scenario, em statements, directed pared questions challenge an emergency the [facility's] response to lumentation of all drills, s, and emergency events the [facility's] emergency the sat §483.73(d):] ty] must conduct exercises ency plan at least twice per lannounced staff drills locy procedures. The [LTC lust do the following: le in an annual full-scale lommunity-based; or in a community-based cessible, conduct an facility-based functional					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

254R21

Facility ID: 000386

If continuation sheet

Page 16 of 37

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING		COMPL	
		155428	B. W	ING		08/10/	2020
NAME OF I	DROWIDED OF GIRDLIE		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	X		2102 S	MERIDIAN ST		
MERIDIA	N NURSING AND	REHABILITATION CENTER		INDIAN	APOLIS, IN 46225		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	BROWINEDIC DE AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
	emergen	cy plan, the LTC facility is					
	exempt from enga	aging its next required a					
	full-scale commur	nity-based or					
	individual, fac	cility-based functional					
	exercise following	the onset of the					
	emergency event.						
	` '	an additional annual					
	-	include, but is not limited					
	to the following:						
	` '	cond full-scale exercise that					
		ed or an individual, facility					
	based functional e	·					
	` '	ock disaster drill; or					
		bletop exercise or workshop cilitator includes a group					
	discussion, using	• '					
	_	vant emergency scenario,					
	· ·	em statements, directed					
	messages, or pre						
		challenge an emergency					
	plan.	3 3 7					
	(iii) Analyze	the [LTC facility] facility's					
	response to and n	naintain documentation of					
	all drills, tabletop	exercises, and emergency					
	events, and revise	the [LTC facility] facility's					
	emergency plan, a	as needed.					
	*[For CF/!!D= -+ 6	1400 47E(d\].					
	*[For ICF/IIDs at §	3483.475(a)]: CF/IID must conduct					
		he emergency plan at least					
		ie ICF/IID must do the					
	following:	ie ici /iib iiidst do tile					
	•	in an annual full-scale					
		mmunity-based; or					
		n a community-based					
		cessible, conduct an					
		facility-based functional					
	exercise						
		ICF/IID experiences an					
	` '	nan-made emergency that					
	I						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

254R21

Facility ID: 000386

If continuation sheet

Page 17 of 37

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	1	A. BUILDING			ETED
		155428	B. W	ING		08/10/	/2020
			•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	PROVIDER OR SUPPLIEF	C		2102 S	MERIDIAN ST		
MERIDIA	N NURSING AND	REHABILITATION CENTER			APOLIS, IN 46225		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	requires activation	n of the emergency					
	I	/IID is exempt from					
	1	xt required full-scale					
	•••	or individual, facility-					
	1	onal exercise following the					
	onset of the emer	_					
		ın additional annual					
	exercise that may	include, but is not limited					
	to the following:						
	(A) A sec	cond full-scale exercise that					
	is community-bas	ed or an individual,					
	facility-based fund	ctional exercise; or					
	(B) A mo	ock disaster drill; or					
		eletop exercise or workshop					
	1	cilitator and includes a					
	group discussion,	_					
	1	vant emergency scenario,					
	· ·	em statements, directed					
	messages, or pre	· · · · · · · · · · · · · · · · · · ·					
	l .	challenge an emergency					
	plan.	1. 105/1151					
		he ICF/IID's response to					
		umentation of all drills,					
	•	s, and emergency events, e ICF/IID's emergency plan,					
	as needed.	e ICF/IID's emergency plan,					
	as needed.						
	*[For OPOs at §48	86.3601					
	'	e OPO must conduct					
		he emergency plan. The					
	OPO must do the	.					
		paper-based, tabletop					
	* * *	hop at least annually. A					
	tabletop exercise	is led by a facilitator and					
	includes a gro	oup discussion, using a					
	narrated, clinically	relevant emergency					
	scenario, and a se	et of problem statements,					
	directed mess	sages, or prepared					
	questions designe	ed to challenge an					
	emergency plan. I	If the OPO experiences an					
	I		- 1				I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

254R21

Facility ID: 000386

If continuation sheet

Page 18 of 37

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155428		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/10/2020	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2102 S MERIDIAN ST INDIANAPOLIS, IN 46225				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	requires activation the OPO is exemp required testinonset of the emerginal conset of the IRNHCI's plan, as needed. Based on record revision facility failed to consergency plan at 1 unannounced staff of procedures. The LT following: (i) Participate in an that is community-based functions. When a community-based functions. If the LTC facility natural or man-madiactivation of the emprace facility is exempt for required full-scale individual, facility-exercise for 1 year factual event. (ii) Conduct an addinctude, but is not liang. A second full-scale community-based of functional exercise. b. A mock disaster of the conservation of the emprace of th	e OPO's response to and station of all tabletop ergency events, and revise and OPO's] emergency iew and interview, the duct exercises to test the east twice per year, including littls using the emergency C facility must do the annual full-scale exercise assed; or ty-based exercise is not an annual individual, onal exercise. If y experiences an actual emergency plan, the LTC omengaging its next in a community-based or pased full-scale functional collowing the onset of the tional exercise that may mited to the following: le exercise that is ran individual, facility-based	E 00)39	E039 EP Testing Requirement 1. What corrective Action will accomplished for those reside found to have been affected by the alleged deficient practice? No residents were affected by alleged deficient practice. The Plan Testing exercise has been scheduled for 8/25/2020 and 12/08/2020. The EP Plan Testing exercise schedule will be reviet and updated at the 8/25/2020 QAPI meeting. Updated testing schedule was added to the EP Plan Binder. 2. How will other residents has the same potential to affected the alleged deficient practice is identified and what corrective action will be taken? No residents were affected by alleged deficient practice. All residents had the potential to affected. 3. What measures will be put	be ints y EP en sting ewed ing by be the be	08/25/2020

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

254R21

Facility ID: 000386

If continuation sheet

Page 19 of 37

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED		
		155428	B. WING		08/10/2020	
			l gmp.ru			
NAME OF P	ROVIDER OR SUPPLIEF	₹		ET ADDRESS, CITY, STATE, ZIP CODE		
				S MERIDIAN ST		
MERIDIAN NURSING AND REHABILITATION CENTER			INDI	ANAPOLIS, IN 46225		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE	
		ge an emergency plan.		place or systemic changes wil	l he	
	_	ΓC facility's response to and		made to ensure that the allege	l l	
		ation of all drills, tabletop		deficient practice does not occ		
		rgency events, and revise the		deficient practice does not occ	oui:	
		gency plan, as needed in		The update and review of the	ED	
	-	CFR 483.73(d)(2). This		Plan Testing Exercise schedu		
					ie	
	deficient practice co	ould affect all occupants.		has been added to the QAPI	,	
	Fig. 41			Calendar for January and July		
	Findings include:			every year to ensure compliar	ice.	
	Based on review of	"Emergency Preparedness		4. How will the corrective acti	on	
		ce Manual" documentation		be monitored to ensure the	011	
	_	4 and "Comprehensive		alleged deficient practice will r	not	
		ement Plan" documentation		occur?	iot	
		the Regional Director		occui :		
		w from 9:40 a.m. to 11:00		QAPI calendars are reviewed		
	a.m. on 08/10/20, d			monthly the QAPI committee		
		lisaster drill or table top		overseen by the administrator	and	
	_	within the most recent		reviewed by corporate risk	and	
		d was not available for review.		management. If threshold of		
	_	at the time of record review,		100% is not achieved an action	n	
		tor agreed the facility has not		plan will be developed to ensu		
	-	unity based disaster drill, a		compliance.	ile	
	table top exercise o	•		compliance.		
	-	-		E. Durushat data will avertamia		
		litional actual natural or		5. By what date will systemic		
		ncy within the most recent		changes be completed?		
		d and agreed testing		0/05/0000		
		not available for review at the		8/25/2020		
	time of the survey.					
K 0000						
1 0000						
Bldg. 01						
Diag. 01	A Life Sefety Code	Recertification and State	IZ 0000	Please accept the following pl	an	
	_		K 0000	of correction for Meridian Nurs		
	_	vas conducted by the Indiana		and Rehab.	sing	
	_	f Health in accordance with		and Renau.		
	42 CFR 483.90(a).					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

254R21

Facility ID: 000386

If continuation sheet Page 20 of 37

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155428 A. BUILDING B. WING	COMPLETED
155428 B. WING	
	08/10/2020
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
2102 S MERIDIAN ST	
MERIDIAN NURSING AND REHABILITATION CENTER INDIANAPOLIS, IN 46225	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERE	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	DATE
Survey Date: 08/10/20	
E 31/2 M 1 000000	
Facility Number: 000386 Provider Number: 155428	
AIM Number: 100286820	
Allyl Nullioci. 100200020	
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 483.90(a), Life Safety from Fire and the	
2012 edition of the National Fire Protection	
Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care	
Occupancies and 410 IAC 16.2.	
Occupancies and 110 IAC 10.2.	
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 smoke detectors in all resident	
sleeping rooms. The facility has a capacity of 44 and had a census of 20 at the time of this survey.	
and had a census of 20 at the time of this survey.	
All areas where residents have customary access	
were sprinklered. All areas providing facility	
services were sprinklered except for two	
detached buildings which were each not	
sprinklered.	
Quality Review completed on 08/12/20	
K 0300 NFPA 101	
SS=F Protection - Other	
Bldg. 01 Protection - Other	
List in the REMARKS section any LSC	
Section 18.3 and 19.3 Protection	
requirements that are not addressed by the	
provided K-tags, but are deficient. This	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

254R21

Facility ID: 000386

If continuation sheet

Page 21 of 37

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155428		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/10/2020		
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		2102 S	ADDRESS, CITY, STATE, ZIP CODE MERIDIAN ST APOLIS, IN 46225		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	information, along Safety Code or NI should be included. Based on record revolution of 20 of 20 battery or resident rooms was 4.6.12.3 states exist obvious to the public Code, shall be maintained the manufacturer's public the requirements of 14.2.1.1.1 Inspection programs shall satistic Code and conform manufacturer's public deficient practice of staff, and visitors with the state of the stat	with the applicable Life FPA standard citation, d on Form CMS-2567. view, interview and ility failed to ensure the preventative maintenance operated smoke alarms in complete. NFPA 101 in ing life safety features ic, if not required by the ttained. NFPA 72, 29.10 tests. Fire-warning equipment and tested in accordance with oublished instructions and per Chapter 14. NFPA 72, in, testing, and maintenance iffy the requirements of this to the equipment ished instructions. This ould affect all residents, ithin the facility. the Battery-operated Smoke ince documentation (resident at 9:52 a.m. with the or, there was no itemized list ttery operated smoke alarms lity on a monthly basis for it of 2020. Based on interview we, the Maintenance Director outery-operated smoke fer recommendations called Based on observations and 11:45 a.m. during a tour the Maintenance Director, oke alarms were observed in	KO		K 300 – Protection-Other 1. What corrective Action will accomplished for those reside found to have been affected by the alleged deficient practice? No residents were affected by alleged deficient practice. All battery-operated smoke alarm resident rooms had batteries replaced, alarms tested, and documentation put in place. Testing of battery-operated sm alarms in resident rooms was on the monthly Preventative Maintenance log for each mor 2. How will other residents had the same potential to affected the alleged deficient practice identified and what corrective action will be taken? No residents were affected by alleged deficient practice. All residents have the potential to affected. 3. What measures will be put place or systemic changes will made to ensure that the alleged deficient practice does not occument of the potential contained to the systemic changes will made to ensure that the alleged deficient practice does not occument of the potential contained to the potential contained to the potential contained to the potential to affected.	s in noke put th. ving by be into be cd cur?	08/25/2020

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

254R21

Facility ID: 000386

If continuation sheet Page 22 of 37

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155428		(X2) MULTIPLE CC A. BUILDING B. WING	01	COMPLETED 08/10/2020		
MERIDIA	PROVIDER OR SUPPLIER IN 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)		cleaning schedule to ensure batteries have been changed and test battery-operated smo alarms to ensure they are functioning properly.	I		
			How will the corrective active be monitored to ensure the alleged deficient practice will roccur.			
			Maintenance Supervisor or designee will review the result inspections monthly by the QA committee overseen by the administrator and reviewed by corporate risk management, monthly times six months and annually. If threshold of 100% not achieved an action plan wideveloped to ensure complian	n is		
			5. By what date will systemic changes be completed? 8/25/2020			
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

254R21

Facility ID: 000386

If continuation sheet

Page 23 of 37

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155428		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/10/2020	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2102 S MERIDIAN ST INDIANAPOLIS, IN 46225				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		TE	(X5) COMPLETION DATE
	b) Who provided c) Water system Provide in REMAR coverage for any automatic sprinkle 9.7.5, 9.7.7, 9.7.8 Based on observation failed to maintain the sprinkle operate at a specific 2010 edition, 8.5.4. between the sprinkle above shall be select sprinkler and the tyndeficient practice of and visitors in the versident room #1 are Findings include: Based on observation Director during a total a.m. to 11:45 a.m. of ceiling tile was mis by janitor's closet 2 with one pendant sysuspended ceiling, time of the observation of the observation of the observation of the aforemention of the foremention of the aforemention of the foremention of the observation of the aforemention of the observation of the observation of the aforemention of the observation of the aforemention of the observation of the obser	supply source RKS information on non-required or partial or system. In and NFPA 25 on and interview, the facility no ceiling construction in 1 of ang tiles trap hot air and gases or and cause the sprinkler to ad temperature. NFPA 13, 1.1 states the distance of the distance of construction. This bould affect 10 residents, staff icinity of the kitchen by did Therapy. The active of the facility from 11:05 on 08/10/20, one suspended ur of the facility from 11:05 on 08/10/20, one suspended or inkler installed on the Based on interview at the tions, the Maintenance ged the missing ceiling tiles ed area.	K 0	353	K 353 – Sprinkler Systems-Maintenance and Te 1. What corrective Action will accomplished for those reside found to have been affected by the alleged deficient practice? No residents were affected by alleged deficient practice. The missing ceiling tile in the kitch entryway has been replaced. 2. How will other residents hat the same potential to affected the alleged deficient practice identified and what corrective action will be taken? No residents were affected by alleged deficient practice. All residents have the potential to affected. 3. What measures will be put place or systemic changes will made to ensure that the alleged deficient practice does not occord	be into I be ed	08/25/2020

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

254R21

Facility ID: 000386

If continuation sheet

Page 24 of 37

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155428	A. BUILDING B. WING	<u>01</u>	COMPL 08/10/	ETED
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	2102 S	ADDRESS, CITY, STATE, ZIP CODE MERIDIAN ST IAPOLIS, IN 46225		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
				Maintenance Supervisor or designee will inspect and cond an audit of all ceiling tiles with facility to ensure they are in plant and functioning properly.	the	
				4. How will the corrective action be monitored to ensure the alleged deficient practice will noccur? 1. Maintenance Supervisor or designee will review the result inspections monthly by the QA committee overseen by the administrator and reviewed by corporate risk management, monthly times six months and annually. If threshold of 100% not achieved an action plan will developed to ensure complian	s of PI is	
				5. By what date will systemic changes be completed?		
K 0355 SS=E Bldg. 01	installed, inspecte accordance with N Portable Fire Extir	nguishers guishers are selected, d, and maintained in IFPA 10, Standard for nguishers.		8/25/2020		
	facility failed to ens	12, NFPA 10 ation and interview, the sure 1 of 8 portable fire aspected at least monthly and	K 0355	K 355 Portable Fire Extinguish	iers	08/25/2020

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

254R21

Facility ID: 000386

If continuation sheet Page 25 of 37

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	١G	01	COMPI	LETED
		155428	B. WING			08/10	/2020
			CTD	PEET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	8					
					MERIDIAN ST		
MERIDIA	N NURSING AND I	REHABILITATION CENTER	INL	JIAN	APOLIS, IN 46225		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID				(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREF	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAC		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		e documented including the			What corrective Action will		
	-	the person performing the			accomplished for those reside		
		dance with NFPA 10. LSC			found to have been affected b		
						•	
	_	ble fire extinguishers shall be			the alleged deficient practice?		
		inspected and maintained in			N		
		FPA 10. NFPA 10, the			No residents were affected by		
		le Fire Extinguishers, 2010			alleged deficient practice. The		
	-	2.1.2 states fire extinguishers			portable fire extinguisher locat		
	-	ither manually or by means of			in the boiler room across from		
		oring device/system at a			resident room #14 has been		
		intervals. Where monthly			inspected and updated.		
	-	are conducted, the date the					
	-	was performed and the initials			How will other residents had	•	
	of the person perfor	ming the inspection shall be			the same potential to affected	by	
	recorded. Where m	anual inspections are			the alleged deficient practice b	oe .	
	conducted, records	for manual inspections shall			identified and what corrective		
	be kept on a tag or l	label attached to the fire			action will be taken?		
	extinguisher, on an	inspection checklist					
	maintained on file,	or by an electronic method.			No residents were affected by		
	Records shall be ke	pt to demonstrate that at least			alleged deficient practice. All		
	the last 12 monthly	inspections have been			residents have the potential to	be	
	_	ficient practice could affect			affected.		
	_	d staff in the vicinity of the					
		from resident room #14.			3. What measures will be put	into	
					place or systemic changes wil		
	Findings include:				made to ensure that the allege		
					deficient practice does not occ		
	Based on observation	ons with the Maintenance			demoistric produces deserved to the	, u	
		our of the facility from 11:05			Maintenance Supervisor or		
	_	on 08/10/20, the portable fire			designee will inspect all portal	مام	
		d in the boiler room across			fire extinguishers on the first	oic .	
	from resident room				Monday of the month.		
					_		
	_	nich did not document a			Administrator or designee will	horo	
		after May 2020. The affixed			audit all portable fire extinguis	ners	
		documented the annual fire			by the 10th of each month to	4	
	-	tion was conducted by a			ensure they have been inspec	iea	
	-	020. Based on interview at			and are up to date.		
		rvations, the Maintenance					
	Director agreed mor						
	documentation after	r May 2020 for the portable			4. How will the corrective active	on	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

254R21

Facility ID: 000386

If continuation sheet

Page 26 of 37

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155428	(X2) MUI A. BUII B. WIN	LDING	NSTRUCTION 01	(X3) DATE : COMPL 08/10/	ETED
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		2102 S I	DDRESS, CITY, STATE, ZIP CODE MERIDIAN ST APOLIS, IN 46225		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	fire extinguisher was 2. Based on observation facility failed to ensextinguishers were not more than one y Standard for Portab Section 7.3.1.1.1 reshall be subjected to not more than 1 year test, or when specifinspection or electrors 3.3.15 defines extin thorough examination that is intended to give extinguisher with safely and to determ condition will prever or replacement is not testing or internal more section 7.3.3 states have a tag or label similar the work, and identify performing the work could affect over 5 findings include: Based on observation Director during a to between 11:05 a.m. fire extinguisher look had a tag on it that the section of the se	ation and interview, the sure 1 of 8 portable fire given maintenance at periods rear apart. NFPA 10, the le Fire Extinguishers, at quires that fire extinguishers of maintenance at intervals of ar, at the time of hydrostatic fically indicated by an onic notification. Section guisher maintenance as a on of the fire extinguisher ive maximum assurance that a ll operate effectively and nine if physical damage or ent its operation, if any repair ecessary, and if hydrostatic maintenance is required. The each fire extinguisher shall securely attached that and year the maintenance intifies the person performing effects the name of the agency k. This deficient practice staff. The each fire facility on 08/10/20 and 11:45 a.m., the portable cated in Mechanical Room 1 was used for over a year. The	P		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	s of	
	and was last checke Based on interview the Maintenance Di	esting date of May 2019 on it d monthly on February 2020. at the times of observations, rector acknowledged the uisher listed above as being in					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

254R21

Facility ID: 000386

If continuation sheet

Page 27 of 37

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	construction <u>01</u>	(X3) DATE SURVEY COMPLETED	
		155428	B. WING		08/10/2020	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	2102	TADDRESS, CITY, STATE, ZIP CODE S MERIDIAN ST NAPOLIS, IN 46225		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
		ely 15 months without being enance at intervals of not more				
	These findings were Administrator at the	e reviewed with the e exit conference.				
	3.1-19(b)					
K 0712 SS=F Bldg. 01	alarm signal and signed fire conditions. Fire expected and une varying conditions shift. The staff is fand is aware that routine. Where di 9:00 PM and 6:00 announcement madible alarms.	ay be used instead of	K 0712	K 712 Fire Drills	08/25/2020	
	facility failed to prosecond quarter fire shift fire drill in the 19.7.1.6 requires dron each shift under deficient practice awithin the facility. Findings include: Based on record revelled Healthcare Fire Drithe Maintenance Dron 08/10/20 at 9:48	ovide documentation of drills and third quarter first alast 12 months. LSC rills to be conducted quarterly varied conditions. This ffects all residents and staff view of the "Chosen ll Report" report form with irector & Regional Director a.m., documentation of fire the first, second and third	K 0/12	1. What corrective Action will accomplished for those reside found to have been affected by the alleged deficient practice? No residents were affected by alleged deficient practice. An Annual Fire Drill Schedule was created that shows the month shift and timeframe fire drills who be conducted in. The Annual Drill Schedule will not be shar outside of the Administrator at Maintenance Director so it will	I be ints y s vill Fire ed ind	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

254R21

Facility ID: 000386

If continuation sheet

Page 28 of 37

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155428	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/10/2020
	PROVIDER OR SUPPLIER	2102 S	ADDRESS, CITY, STATE, ZIP CODE MERIDIAN ST IAPOLIS, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
IAG	shift in the second quarter (April, May, June) 2020 were not available for review. Documentation of a fire drill conducted on the first shift in the third quarter (July, August, September) 2020 was not available for review. Based on interview at the time of record review, the Regional Director acknowledged that documentation of a fire drill conducted on the aforementioned shifts within the most recent twelve month period was not available for review at the time of the survey. She indicated that the facility has had Maintenance staffing issues and turnover. This deficiency was discussed and acknowledged by the facility Administrator at the exit conference. 3.1-19(b) 3.1-51(c)	IAG	be random and unannounced staff. 2. How will other residents had the same potential to affected the alleged deficient practice identified and what corrective action will be taken? No residents were affected by alleged deficient practice. All residents have the potential to affected. 3. What measures will be put place or systemic changes will made to ensure that the alleged deficient practice does not occur. An Annual Fire Drill Schedule created that shows the month shift and timeframe fire drills who be conducted in. The Annual Drill Schedule will not be shar outside of the Administrator and Maintenance Director so it will be random and unannounced staff. Maintenance Supervisor designee will conduct an audit all fire drills conducted. 4. How will the corrective active monitored to ensure the alleged deficient practice will record.	into libe ed cur? was vill Fire ed nd still to r or t of
			designee will review the result	s of

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

254R21

Facility ID: 000386

If continuation sheet

Page 29 of 37

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155428	B. WING		08/10/2020
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	2102 S	ADDRESS, CITY, STATE, ZIP CODE MERIDIAN ST IAPOLIS, IN 46225	
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID	PROVIDEDS BLANGE CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
				inspections monthly by the QA committee overseen by the administrator and reviewed by corporate risk management, monthly times six months and annually. If threshold of 100% not achieved an action plan wi developed to ensure complian 5. By what date will systemic changes be completed? 8/25/2020	is Il be
K 0911 SS=F Bldg. 01	Chapter 6 Electrica that are not address K-Tags, but are de along with the app NFPA standard cits on Form CMS-256 Chapter 6 (NFPA standard on observation failed to ensure access maintained in encloss apparatus in 1 of 1 r Health Care Facilities Section 6.3.2.1 states be in accordance will Electric Code. NFPA 110.26 states working operating at 600 volto require examination maintenance while of the dimensions of 1	S - Other LKS section any NFPA 99 al Systems requirements ssed by the provided efficient. This information, licable Life Safety Code or eation, should be included	K 0911	K 911 Electrical Systems – Ott 1. What corrective Action will accomplished for those reside found to have been affected by the alleged deficient practice? No residents were affected by alleged deficient practice. All items have been removed from front of electrical panel in the Mechanical Room located on the second of th	be nts y

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

254R21

Facility ID: 000386

If continuation sheet

Page 30 of 37

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES	[X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155428	B. WING		08/10/2020
MANGOES	DOLUDED OF GURNING		STREE	T ADDRESS, CITY, STATE, ZIP CODE	•
NAME OF P	ROVIDER OR SUPPLIER	<u>:</u>	2102	S MERIDIAN ST	
MERIDIA	N NURSING AND I	REHABILITATION CENTER		NAPOLIS, IN 46225	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	J
TAG	•	LSC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE DATE
1710		posed or from the enclosure	1110	south side of the building.	BATE
		such are enclosed. Article		South side of the building.	
		e working space required by		2. How will other residents	having
		t be used for storage. This		the same potential to affecte	9
		ould affect at least one to ten		the alleged deficient practice	-
	_	ne mechanical rooms.		identified and what correctiv	
				action will be taken?	
	Findings include:				
				No residents were affected I	by
	Based on observation	ons on 08/10/20 during tour		alleged deficient practice. A	
	between 11:05 a.m.	to 11:45 a.m. with the		residents have the potential	to be
	Maintenance Direct	or at 11:44 a.m. the		affected.	
	Mechanical Room	located on the south side of			
	the building by an e	exit door had flat screen		3. What measures will be p	ut into
	-	le stacked in front of the		place or systemic changes v	
	_	ased on interview at the time		made to ensure that the alle	
		Maintenance Director		deficient practice does not o	occur?
	_	tored items were present and			
	would have to be re	moved.		Maintenance Supervisor or	
				designee will conduct an au	
	_	viewed with the Administrator		Mechanical Rooms weekly t	
	at the exit conference	ce.		ensure electrical panel is no	t
	2.1.10(1)			blocked.	
	3.1-19(b)				
				4 How will the corrections	otion
				4. How will the corrective as be monitored to ensure the	CUOTI
					II not
				alleged deficient practice will occur?	II TIOL
				1.	
				Maintenance Supervisor or	
				designee will review the auc	lits
				monthly by the QAPI commi	
				overseen by the administrat	
				reviewed by corporate risk	
				management, monthly times	s six
				months and annually. If three	
				of 100% is not achieved an	
				plan will be developed to en	
				compliance	
				1 '	

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155428	A. BUILDING B. WING	<u>01</u>	COMPLETED 08/10/2020
	ROVIDER OR SUPPLIER N NURSING AND F	REHABILITATION CENTER	2102 S	ADDRESS, CITY, STATE, ZIP CODE MERIDIAN ST APOLIS, IN 46225	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
				5. By what date will systemic changes be completed?8/25/2020	
K 0914 SS=F Bldg. 01	Testing Electrical Systems Testing Hospital-grade recolocations and when general anesthesia tested after initial inservicing. Addition intervals defined be performance data, hospital-grade at the intervals not exceed isolation monitors tested at intervals month by actuating 6.3.2.6.3.6, which audible alarm. For automated self-test performed at interval 2 months. LIM circles 12 months. LIM circles 12 months. LIM circles 13.3.3.2 after any electric distribution maintained of requirepairs or modification or area tested 6.3.4 (NFPA 99)	Receptacles not listed as these locations are tested at eding 12 months. Line (LIM), if installed, are of less than or equal to 1 g the LIM test switch per activates both visual and LIM circuits with ting, this manual test is vals less than or equal to require are tested per repair or renovation to the a system. Records are tired tests and associated tions, containing date,	K 0914	K914 – Electrical Systems –	08/25/2020

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

254R21

Facility ID: 000386

If continuation sheet Page 32 of 37

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	01	COMPL	ETED
		155428	B. W	ING		08/10/	2020
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	₹					
MEDIDIA	NI NILIDOINIO AND I	DELIADU ITATIONI OENITED			MERIDIAN ST		
MERIDIA	IN NURSING AND	REHABILITATION CENTER		INDIAN	APOLIS, IN 46225		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	12	DATE
	interview, the facili	ty failed to ensure all			Maintenance & Testing		
	nonhospital-grade e	electrical receptacles in 20 of					
	20 resident room lo	cations were tested at least			1. What corrective Action will	be	
	annually. NFPA 99	, Health Care Facilities Code			accomplished for those reside	nts	
	2012 Edition, Section	on 6.3.4.1.3 states			found to have been affected by	y	
	receptacles not liste	ed as hospital-grade, at patient			the alleged deficient practice?	-	
	bed locations and ir	locations where deep					
		anesthesia is administered,			All electrical receptacles will be	е	
	shall be tested at int	tervals not exceeding 12			tested by 8/25/2020 for correc	t	
	months. Additional	ly, Section 6.3.3.2,			polarity and retention force and	d	
	Receptacle Testing	in Patient Care Rooms			results will be documented.		
	requires the physica	al integrity of each receptacle					
	shall be confirmed by visual inspection. The				2. How will other residents ha	ving	
	continuity of the gr	ounding circuit in each			the same potential to affected	by	
	electrical receptacle	e shall be verified. Correct			the alleged deficient practice b	e	
	polarity of the hot a	and neutral connections in			identified and what corrective		
	each electrical rece	ptacle shall be confirmed;			action will be taken?		
	and retention force	of the grounding blade of					
	each electrical rece	ptacle (except locking-type			No residents were affected. A	JI.	
	receptacles) shall be	e not less than 115 grams (4			outlet receptacles have been		
	ounces). This defici	ient practice could affect all			tested.		
	residents.						
					3. What measures will be put	into	
	Findings include:				place or systemic changes will	l be	
					made to ensure that the allege	ed	
	Based on record rev	view on 08/10/20 between			deficient practice does not occ	cur?	
	9:30 a.m. and 11:00	a.m. with the Maintenance					
	Director & Regiona	al Director, there was no			The Maintenance Supervisor of	or	
	record of an annual	test for each resident room			designee will inspect plugs		
	electrical receptacle	e that was not a			monthly and replace according	gly.	
	hospital-grade recep	ptacle. Based on interview at			Maintenance Supervisor will		
	the time of record re	eview, the Regional Director			complete inspection form with	his	
	said she had the ins	pection form, but it had not			findings. Once a new		
	been completed, so	there was no record or			maintenance director has beer	n	
	documentation to sl	now that annual testing per			obtained, will be educated on		
	NFPA 99, Receptac	ele Testing requirements was			proper procedure and		
	met. Based on obse	rvations between 11:05 a.m.			documentation of preventative	:	
	and 11:45 a.m. duri	ng a tour of the facility with			maintenance.		
	the Maintenance Di	rector, there were at least					
	four to six electrica	l receptacles in each of the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

254R21

Facility ID: 000386

If continuation sheet Page 33 of 37

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155428	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/10/2020
	PROVIDER OR SUPPLIER AN NURSING AND REHABILITATION CENTER	2102 S	ADDRESS, CITY, STATE, ZIP CODE MERIDIAN ST IAPOLIS, 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 APPROPRIA DEFICIENCY)	DATE
	resident rooms. This finding was reviewed with the Administrator at the exit conference.		4. How will the corrective acti be monitored to ensure the alleged deficient practice will r occur?	
	3.1-19(b)		Maintenance Supervisor or designee will review the result inspections monthly by the QA committee overseen by the administrator and reviewed by corporate risk management, monthly times six months and annually. If threshold of 100% not achieved an action plan w developed to ensure compliant 5. By what date will systemic changes be completed	API , o is ill be
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

254R21

Facility ID: 000386

If continuation sheet

Page 34 of 37

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	01	COMPL	ETED
		155428	B. W	ING		08/10/	/2020
				CTDEET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
MEDIDIA	NI NILIDOINIC AND	REHABILITATION CENTER			MERIDIAN ST IAPOLIS, IN 46225		
MEKIDIA	IN NURSING AND	REHABILITATION CENTER		INDIAN	IAPOLIS, IN 40225		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ls. All power strips are					
	_	precautions. Extension					
	cords are not used as a substitute for fixed						
	-	re. Extension cords used					
		moved immediately upon					
		purpose for which it was					
		ts the conditions of 10.2.4.					
	,	9), 10.2.4 (NFPA 99),					
		590.3(D) (NFPA 70), TIA					
	12-5	and the second			14000 FL () FL ()		00/07/000
		ation and interview, the	K 0	920	K920 – Electrical Equipment –	•	08/25/2020
		sure a power strip was not			Power Cords & Extensions		
		for fixed wiring in 1 of 1			4 NA/hat as mastive Astion will	h -	
		requires electrical wiring and			What corrective Action will		
		ly with NFPA 70, National FPA 70, Article 400-8			accomplished for those reside found to have been affected b		
		cifically permitted, flexible			the alleged deficient practice?	-	
	-	all not be used as a substitute			the alleged delicient practice:		
		astructure. This deficient			Power strips that meet the Me	dical	
		et all staff in the kitchen.			Grade UL 1363A replaced	dicai	
	practice could affect	the diff staff in the kitchen.			previously used power strips,		
	Findings include:				where applicable. Residents	were	
	i mumgo moraue.				educated not to plug anything		
	Based on observation	on on 08/10/20 at 11:06 a.m.			the power strips except medic		
		facility with the Maintenance			equipment.		
		an ice machine plugged into a			' '		
		itchen next to Janitor's Closet			2. How will other residents ha	ving	
		power strip was laying on a			the same potential to affected	•	
	-	ased on interview at the time			the alleged deficient practice b	-	
	of observation, the	Maintenance Supervisor			identified and what corrective		
	acknowledged the u	use of the power strip and said			action will be taken?		
	he would plug the i	ce machine into a wall outlet.					
					No other residents were affect		
		ation and interview, the			by this practice. Medical Grad		
		sure in 1 of 1 therapy area,			UL 1363A power strips have b		
		not used as a substitute for			placed into each resident roon	ก.	
		9.1.2 requires electrical wiring					
		l be in accordance with NFPA			3. What measures will be put		
		cal Code. NFPA 70, 2011			place or systemic changes wil		
	Edition, Article 400	0.8 requires that, unless			made to ensure that the allege	∌d	

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155428	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/10/2020
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	2102 S	ADDRESS, CITY, STATE, ZIP CODE MERIDIAN ST JAPOLIS, IN 46225	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ed, flexible cords and cables	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY) deficient practice does not oc	DATE
	shall not be used as of a structure. This affect 5 residents ar Findings include: Based on observation Director on 08/10/2 100 foot extension of into a power strip in the power strip were a lamp. This cord we fans that could not be	as substitute for fixed wiring deficient practice could d staff in therapy area. on with the Maintenance 0 at 11:11 a.m. one orange cord was found to be plugged a therapy. Also plugged into the two fans, an air purifier and as used to provide power to be plugged into fixed wiring terview at the time of the		Maintenance Supervisor or designee will inspect rooms of monthly deep clean to ensure power strips being utilized are the appropriate grade and the items were not plugged in the shouldn't be. 4. How will the corrective act be monitored to ensure the alleged deficient practice will occur	uring e any e of at t
	3. Based on observation facility failed to ensure did not use flexible fixed wiring. LSC 9 and equipment shal 70, National Electric Edition, Article 400	intenance Director se of the orange extension ation and interview, the ure 1 of 1 mechanical room cords as a substitute for 1.1.2 requires electrical wiring the in accordance with NFPA cal Code. NFPA 70, 2011 .8 requires that, unless ed, flexible cords and cables		Maintenance Supervisor or designee will review the result inspections monthly by the Queromittee overseen by the administrator and reviewed by corporate risk management, monthly times six months and annually. If threshold of 100% not achieved an action plan will developed to ensure compliants. By what date will systemic changes be completed?	API y i is iil be ince
	of a structure. This to 1 staff only. Findings include: Based on observation	a substitute for fixed wiring deficient practice affects up on with the Maintenance		8/25/2020	
	room 1 had a multi- wall outlet. This mu a portable drill char	0 at 11:44 a.m. Mechanical plug adapter plugged into a alti-plug adapter was powering ger in the vicinity of fuel within the room. Based on			

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

l I		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155428	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/10/2020		
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	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG				TAG	DEFICIENCY)		DATE	
	interview at the time of the observation, the Maintenance Director acknowledged the use of the multi-plug adapter, stated that it had been there since before he had started working at the facility, and that he did not know that multi-plug adapters were not allowed to be in use. These deficiencies were discussed and acknowledged by the facility Administrator at the exit conference.							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

254R21

Facility ID: 000386

If continuation sheet

Page 37 of 37