STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155325	A. BUILDING -- B. WING	03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/31/25 Facility Number: 000218 Provider Number: 155325 AIM Number: 100274800 At this Emergency Preparedness survey, Meadow View Health and Rehabilitation Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has a capacity of 98 certified beds and had a census of 75 at the time of this visit. Quality Review completed on 04/04/25	E 0000	Plan of Corrections is listed below in Section K 0921. The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/31/25 Facility Number: 000218 Provider Number: 155325 AIM Number: 100274800 At this Life Safety Code survey, Meadow View	K 0000	Plan of Corrections is listed below in Section K 0921. The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Krista Smith	Executive Director	04/28/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155325	A. BUILDING 01 B. WING	03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Health 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. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 98 and had a census of 75 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered except one detached wood framed storage shed. Quality Review completed on 04/04/25		Credible Allegation of Compliance and requests a desk review in lieu of a post survey review.	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on record review, observation, and interview; the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification.	K 0921	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: • Residents did not have ill effects related to this alleged deficient practice. Testing has been completed of PCREE for electric beds, nebulizers, oxygen concentrators, air pumps and other electrical equipment by Maintenance Director designee.	05/06/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155325	A. BUILDING 01 B. WING	03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice could affect all residents. Findings include: Based on record review on 03/31/25 at 11:30 a.m. with the Maintenance Director, Regional Maintenance Director, and Executive Director present, there was no documentation for the testing of PCREE, such as electric beds, nebulizers, oxygen concentrators, air pumps for air mattresses, and other electrical medical equipment. Based on interview at the time of record review, the Maintenance Director said the facility has not tested and documented the PCREE items, but was aware of the requirement. Based on observations between 11:45 a.m. and 2:00 p.m. during a tour of the facility with the Maintenance Director, Regional Maintenance Director, and Executive Director, it was revealed the facility provided PCREE such as electric beds, oxygen concentrators, air pumps for air mattresses, and other electrical medical equipment was present in the facility.		How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: • All residents have the potential to be affected by the alleged deficient practice. • 100% audit of electrical equipment was completed 4.10.2025. Document attached. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: • Electrical Safety Inspection PCREE form was developed to record PCREE in the facility. • Maintenance Director/designee will complete PCREE testing before equipment is put into service, as well as after any repair or modification. • Electrical equipment instructions and maintenance manuals will be maintained by the ED and/or Maintenance Director. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie. what quality assurance program will be put into place: Maintenance Director/designee will maintain the record of electrical equipment tests, repairs, and modifications to demonstrate compliance. QAPI tool to audit any new or repaired equipment for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155325	A. BUILDING 01 B. WING	03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This finding was reviewed with the Maintenance Director, Regional Maintenance Director, and Executive Director during the exit conference. 3.1-19(b)		compliance will be implemented monthly. If 95% compliance is not achieved, an action plan will be implemented to correct the outliers. ADDENDUM K 921 E Electrical Equipment – Testing and Maintenance Requirements Original POC documentation corrected to include the date of the original PCREE testing, 4.10.2025, and the name of the tester: Maintenance Designee, Edward Hakes, Senior Maintenance Supervisor. Beds will be re-tested to specifications of NFPA 99 2012 edition, sections 10.3 and 10.5 by stated date of compliance: 5.6.2025. Email from John Elzinga, ASC Vice President of Property Management and Construction. Documentation from Joerns attached, related to Class II equipment.	