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	02/21/2023

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: 02/21/23 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 72 at the time of this visit. Quality Review completed on 02/27/23	E 0000	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: 02/21/23 Facility Number: 000218 Provider Number: 155325 AIM Number: 100274800 At this Life Safety Code survey, Meadow View	K 0000	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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Krista Smith	Executive Director	03/15/2023

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	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 72 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 02/27/23			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of			

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	the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure the corridor doors to 1 of over 10 hazardous area doors, such as an Activity Office/storage room door, was provided with a self closing device. This deficient practice could affect up to 10 residents, staff, and visitors while in the same smoke compartment as the Activity Office/storage room. Findings include: Based on observations on 02/21/23 between 11:45 p.m. and 1:45 p.m. during a tour of the facility with the Maintenance Supervisor, Director of Properties Management, and Executive Director, the Activity Office/storage room was over 50 square feet in size, and full of combustible items such as cardboard boxes, plastic totes, paper, and plastic items plus other combustible storage items. The corridor door to this room was not provided with a self closing device to ensure the door	K 0321	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. • Self closing device installed on Activity Door. 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: • Residents have the potential to be affected by the alleged deficient practice. • Self closing device was installed on Activity Door. Office is located in the Administration hallway, not on a resident hall. Image attached.	03/22/2023

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	would close automatically. Based on interview at the time of observation, the Maintenance Supervisor agreed the door to this hazardous area room did not self close automatically when tested. This finding was reviewed with the Maintenance Supervisor, Director of Properties Management, and Executive Director during the exit conference. 3.1-19(b)		What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: • Combustibles stored within the Activities Office are contained behind a self closing door. • Maintenance Supervisor/designee will round monthly for 6 months with 2023 Life Safety Audit Tool to ensure self-closing devices are operating correctly on areas of storage over 50 sq ft, per requirement. 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 conduct audits by incorporating an inspection of Hazardous Areas into monthly QAPI Environmental Checklist tool x 6 months. All noted audit tool results to be reviewed Monthly at QAPI meeting. If 95% compliance is not achieved, an action plan will be implemented. By what date the systemic changes will be completed: 3/22/2023	
K 0331 SS=E	NFPA 101 Interior Wall and Ceiling Finish			

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Bldg. 01	Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). Based on observation and interview, the facility failed to ensure 1 of 8 smoke compartments was provided with a complete interior finish with a flame spread rating of Class A or Class B for a sprinklered facility. LSC 3.3.90.4 defines interior wall finish as the interior finish of columns, fixed or movable walls, and fixed or movable partitions. A.3.3.90.2 states interior finish is not intended to apply to surfaces within spaces such as those that are concealed or inaccessible. This deficient practice could affect up to 10 residents, staff, and visitors while in the same smoke compartment. Findings include: Based on observations on 02/21/23 between 11:45 a.m. and 1:45 p.m. during a tour of the facility with the Maintenance Supervisor, Director of Properties Management, and Executive Director, there was an eight foot by eight foot wall within the Beauty Shop that was constructed of non fire rated plywood on one side. This was acknowledged by the Maintenance Supervisor at the time of observation, furthermore, the Maintenance Supervisor said the plywood wall did not have a flame spread rating as far as he knew.	K 0331	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. • Area was drywalled and painted with appropriate materials. 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: • Residents have the potential to be affected by the alleged deficient practice. • Area was drywalled and painted. Image attached. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: • Maintenance Supervisor/designee will round monthly for 6 months with 2023	03/22/2023

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	This finding was reviewed with the Maintenance Supervisor, Director of Properties Management, and Executive Director during the exit conference. 3.1-19(b)		Life Safety Audit Tool to ensure smoke compartments have a complete interior finish and meet requirements. 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 Supervisor/designee will conduct audits by incorporating an inspection of Smoke Compartment finishes into monthly QAPI Environmental Checklist tool x 6 months. All noted audit tool results to be reviewed Monthly at QAPI meeting. If 95% compliance is not achieved, an action plan will be implemented. By what date the systemic changes will be completed: 3/22/2023 Salon: self-closer installed, walls drywalled and painted	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage			

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	of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of 2 corridor doors to the kitchen would latch into its door frame. This	K 0363	What corrective action(s) will be accomplished for those residents found to have been affected by the	03/22/2023

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	deficient practice could affect up to 10 residents, staff and visitors. Findings include: Based on observations on 02/21/23 between 11:45 a.m. and 1:45 p.m. during a tour of the facility with the Maintenance Supervisor, Director of Properties Management, and Executive Director, the left side kitchen door to the corridor was not provided with a latching device to latch into its door frame. The door was equipped with a magnetic locking device with a keypad to open. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the kitchen corridor door was not provided with a latching device. This finding was reviewed with the Maintenance Supervisor, Director of Properties Management, and Executive Director, during the exit conference. 3.1-19(b)		deficient practice: • Residents did not have ill effects related to this alleged deficient practice. • Kitchen door handle was replaced with a knob that latches into the door frame. 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: • Residents have the potential to be affected by the alleged deficient practice. • Door knob replaced with a handle that latches into the door frame. Image attached. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: • ED/designee will round monthly for 6 months with 2023 Life Safety Audit Tool to ensure preventative measures for latching door knobs meet requirements. 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 conduct audits by incorporating an inspection of Latching Door Handles into monthly QAPI Environmental	

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			Checklist tool x 6 months. All noted audit tool results to be reviewed Monthly at QAPI meeting. If 95% compliance is not achieved, an action plan will be implemented. By what date the systemic changes will be completed: 3/22/2023 Kitchen Door: door knob which latches into doorframe /p>	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and			

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	safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview, the facility failed to ensure cigarette butts were properly disposed of at 1 of 1 area where cigarettes were smoked by residents. This deficient practice could affect at least 5 residents and staff. Findings include: Based on observations on 02/21/23 between 11:45 a.m. and 1:45 p.m. during a tour of the facility with the Maintenance Supervisor, Director of Properties Management, and Executive Director, the resident smoking area in the courtyard had a large plastic waste basket full of paper trash mixed with hundreds of cigarette butts. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the paper trash mixed with cigarette butts in the large plastic waste basket. This finding was reviewed with the Maintenance Supervisor, Director of Properties Management, and Executive Director during the exit conference. 3.1-19(b)	K 0741	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. • Metal, red, self-closing cover devices replaced the plastic waste receptacles in the smoking area. 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: • Residents have the potential to be affected by the alleged deficient practice. • Plastic waste receptacles were replaced with metal, red, self-closing covered cans in the smoking area. Image attached. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: • Maintenance Supervisor/designee will round monthly for 6 months with 2023 Life Safety Audit Tool to ensure only metal self-closing, covered	03/22/2023

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			containers are used in smoking areas. 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 Supervisor/designee will conduct audits by incorporating an inspection of smoking receptacles into monthly QAPI Environmental Checklist tool x 6 months. All noted audit tool results to be reviewed Monthly at QAPI meeting. If 95% compliance is not achieved, an action plan will be implemented. By what date the systemic changes will be completed: 3/22/2023 Smoking: metal container with self-closing cover /p> /p>	