STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	X2) MULTIPLE CONSTRUCTION (X3) DATE SURV		SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING		COMPL	ETED
		155325	B. WIN	NG		02/21/	2023
			'	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L			SON ST		
	V VIEW HEALTH A	ND REHABILITATION			, IN 47167		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	COMPLETION	
TAG E 0000	REGULATORY OR	LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
⊏ 0000							
Bldg							
~g.	An Emergency Prer	paredness Survey was	E 00	00	This provider respectfully requ	ests	
		diana Department of Health in	200		that this 2567 Plan of Correction		
	accordance with 42	-			be considered the Letter of		
					Credible Allegation of Complia	nce	
	Survey Date: 02/21	./23			and requests a desk review in of a post survey review.	lieu	
	Facility Number: 0	00218			5. a post sairs y lovion.		
	Provider Number:						
	AIM Number: 1002	274800					
		Preparedness survey, Meadow					
		ehabilitation Center was found					
	-	Emergency Preparedness Iedicare and Medicaid					
	-	lers and Suppliers, 42 CFR					
	483.73	icis and Suppliers, 42 Cr R					
	The facility has a co	apacity of 98 certified beds and					
	•	at the time of this visit.					
	Quality Paviana	unlated on 02/27/22					
	Quality Review con	inpicted off 02/2//23					
K 0000							
Bldg. 01							
] ,,,,,	A Life Safety Code	Recertification and State	K 00	000	This provider respectfully requ	ests	
		as conducted by the Indiana			that this 2567 Plan of Correction		
	-	th in accordance with 42 CFR			be considered the Letter of		
	483.90(a).				Credible Allegation of Complia		
	G F 06/64	/22			and requests a desk review in	lieu	
	Survey Date: 02/21	./25			of a post survey review.		
	Facility Number: 0	00218					
	Provider Number:						
	AIM Number: 1002	274800					
	At this Life Safety (Code survey, Meadow View					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Krista Smith Executive Director 03/15/2023

Any defiency statement 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 disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155325	I '	ILDING	nstruction 01	COM	e survey pleted 1/2023
MEADO	ı	ND REHABILITATION		900 ANS SALEM,	ddress, city, state, zip c SON ST IN 47167	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 0321 SS=E Bldg. 01	compliance with Ref Medicare/Medicaid Life Safety from Fi National Fire Protect Life Safety Code (I Health Care Occupa This one story facil Type V (000) const sprinklered. The fa with hard wired sm and spaces open to operated smoke det rooms. The facility census of 72 at the ref were sprinklered an services were sprink wood framed storag Quality Review cor NFPA 101 Hazardous Areas Hazardous areas Hazardous areas	idents have customary access d all areas providing facility klered except one detached se shed. Inpleted on 02/27/23 - Enclosure					
	(with 3/4 hour fire automatic fire exti accordance with 8 approved automatic option is used, the from other spaces	rated doors) or an nguishing system in 8.7.1 or 19.3.5.9. When the tic fire extinguishing system areas shall be separated by smoke resisting					
	Doors shall be sel automatic-closing nonrated or field-a	rs in accordance with 8.4. f-closing or and permitted to have applied protective plates that inches from the bottom of					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPI	LETED
		155325	B. WI	NG		02/21	/2023
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹					
MEADON	۸/ \/IE\۸/ ⊔E۸I T⊔ ۸	ND REHABILITATION	900 ANSON ST SALEM, IN 47167				
IVIEADOV	· VIEVVIIEALIA	NETIABILITATION		SALEIVI	, IIV +/ IU/		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	1	PREFIX	TIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY)		DATE
	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					
	'	N/A					
		-Fired Heater Rooms					
	, -	er than 100 square feet)					
	-	nance, and Paint Shops					
	d. Soiled Linen Rooms (exceeding 64						
	gallons)	_					
	e. Trash Collectio						
	(exceeding 64 gal	•					
		orage Rooms/Spaces					
	(over 50 square fo	•					
	,	classified as Severe					
	Hazard - see K32	•					00/05/55
		on and interview, the facility	K 03	321	What corrective action(s) will be		03/22/2023
		corridor doors to 1 of over 10			accomplished for those reside		
		rs, such as an Activity			found to have been affected b	y the	
		n door, was provided with a			deficient practice:		
	_	This deficient practice could			Residents did not have ill effective in the second se		
	_	dents, staff, and visitors while			related to this alleged deficien	τ	
		compartment as the Activity			practice.		
	Office/storage roon	n.			Self closing device installed	on	
	Findings in abod				Activity Door.		
	Findings include:				How other residents having the		
	Raced on observation	ons on 02/21/23 between 11:45			potential to be affected by the		
		during a tour of the facility with			same deficient practice will be identified and what corrective	;	
		apervisor, Director of			action(s) will be taken:		
		ment, and Executive Director,			Residents have the potential	l to	
		storage room was over 50			be affected by the alleged def		
	· ·	and full of combustible items			practice.	ioi o i il	
		poxes, plastic totes, paper, and			Self closing device was instal	مالم	
		ther combustible storage items.			on Activity Door. Office is loca		1
		o this room was not provided			-		
					in the Administration hallway,		
	with a sell closing of	device to ensure the door	1		on a resident hall. Image attac	inea.	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155325	(X2) MULTIPLE C A. BUILDING B. WING	O1	COME	E SURVEY PLETED 1/2023
	PROVIDER OR SUPPLIER	ND REHABILITATION	900 At	ADDRESS, CITY, STATE, ZII NSON ST M, IN 47167	P COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	CORRECTION N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	the time of observa Supervisor agreed t room did not self el This finding was re Supervisor, Directo and Executive Dire 3.1-19(b)	atically. Based on interview at tion, the Maintenance he door to this hazardous area lose automatically when tested. viewed with the Maintenance or of Properties Management, ctor during the exit conference.		What measures will place and what syste will be made to ensure deficient practice doe • Combustibles store Activities Office are of behind a self closing • Maintenance Supervisor/designee monthly for 6 months Life Safety Audit Too self-closing devices a correctly on areas of 50 sq ft, per requirent. How the corrective a monitored to ensure practice will not recur quality assurance proput into place: Maintenance Director will conduct audits by incorporating an inspectation of the properties o	emic changes are that the es not recur: ed within the contained a door. e will round s with 2023 bl to ensure are operating f storage over ment. ection(s) will be the deficient ar, ie. what ogram will be or/designee y bection of to monthly I Checklist tool d audit tool ed Monthly at w compliance ection plan will estemic	
K 0331 SS=E	NFPA 101 Interior Wall and 0	Ceiling Finish				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED			ETED	
		155325	B. W	NG		02/21/	2023
				CED FEE	ADDRESS OF A STATE OF COD		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
MEADOW		ND DELIADII ITATION			SON ST		
MEADOV	V VIEW HEALTH A	ND REHABILITATION		SALEIVI	l, IN 47167		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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
Bldg. 01	Interior Wall and C	Ceiling Finish					
	2012 EXISTING						
	Interior wall and c	eiling finishes, including					
	exposed interior s	urfaces of buildings such					
	as fixed or movab	le walls, partitions,					
	columns, and have	e a flame spread rating of					
	Class A or Class B	3. The reduction in class of					
	interior finish for a	sprinkler system as					
	prescribed in 10.2						
	10.2, 19.3.3.1, 19.3.3.2						
	Indicate flame spr	ead rating(s).					
		on and interview, the facility	K 0	331	What corrective action(s) will b		03/22/2023
		f 8 smoke compartments was			accomplished for those reside		
	_	nplete interior finish with a			found to have been affected by	y the	
		of Class A or Class B for a			deficient practice:		
		LSC 3.3.90.4 defines interior			Residents did not have ill effe		
		terior finish of columns, fixed			related to this alleged deficient	İ	
		nd fixed or movable partitions.			practice.		
		terior finish is not intended to			Area was drywalled and pain	ted	
		ithin spaces such as those			with appropriate materials.		
		or inaccessible. This deficient			l., " ., ., "		
	_	t up to 10 residents, staff, and			How other residents having the	е	
	visitors while in the	same smoke compartment.			potential to be affected by the		
	F' 1' ' 1 1				same deficient practice will be		
	Findings include:				identified and what corrective		
	Dagad on abassured:	ons on 02/21/23 between 11:45			action(s) will be taken:	t-0	
					Residents have the potential		
	_	during a tour of the facility with upervisor, Director of			be affected by the alleged defi	cient	
		ment, and Executive Director,			practice.	tod	
		oot by eight foot wall within			 Area was drywalled and pain Image attached. 	i c u.	
	_	at was constructed of non fire			i inage attached.		
	rated plywood on or				What measures will be put into	,	
		ne Maintenance Supervisor at			place and what systemic chan		
		tion, furthermore, the			will be made to ensure that the	-	
		visor said the plywood wall			deficient practice does not rec		
	•	e spread rating as far as he			Maintenance	uI.	
	knew.	e opreud runng ao iai ao iic			Supervisor/designee will round	4	
	RHOW.				monthly for 6 months with 202		
			1			J	

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	OF CORRECTION	IDENTIFICATION NUMBER 155325	A. BUILDING B. WING	01	COMPLETED 02/21/2023
	ROVIDER OR SUPPLIER	ND REHABILITATION	900 AN	ADDRESS, CITY, STATE, ZIP COD NSON ST //, IN 47167	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	This finding was rev Supervisor, Director	viewed with the Maintenance of Properties Management, extor during the exit conference.		Life Safety Audit Tool to ensus moke compartments have a complete interior finish and many requirements. How the corrective action(s) monitored to ensure the deficing practice will not recur, ie. what quality assurance program with put into place: Maintenance Supervisor/desi will conduct audits by incorporating an inspection of Smoke Compartment finishes monthly QAPI Environmental Checklist tool x 6 months. All noted audit tool results to be reviewed Monthly at QAPI meeting. If 95% compliance in achieved, an action plan will implemented. By what date the systemic changes will be completed: 3/22/2023 Salon: self-closer installed, with drywalled and painted	will be sient at ill be ignee of s into
K 0363 SS=E Bldg. 01	than required encl	orridor openings in other osures of vertical openings, s areas resist the passage		drywaned and painted	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155325		A. BUILDING 01 COMPLE B. WING 02/21/2					
	PROVIDER OR SUPPLIER	R ND REHABILITATION	90	00 ANS	DDRESS, CITY, STATE, ZIP COD SON ST IN 47167		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		O EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containin combustible mater hardware. Roller la CMS regulation. Tapply to auxiliary sflammable or combustible mater covering is not except doors complying wife provided with a content of the door closed what applied. There is closing of the door release when the copermitted. Nonrate unlimited height are meeting 19.3.6.3.6 frames shall be late other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restrict resistance of glass assemblies. 19.3.6.3, 42 CFR 1483, and 485 Show in REMARK fire protection ratin devices, etc. Based on observation	made of 1 3/4 inch a wood or other material ag fire for at least 20 fully sprinklered smoke a only required to resist the a. Corridor doors and doors ag flammable or rials have positive latching atches are prohibited by These requirements do not spaces that do not contain abustible material. In bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping hen a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are ed protective plates of re permitted. Dutch doors 6 are permitted. Door beled and made of steel or compliance with 8.3,	K 0363		What corrective action(s) will b		03/22/2023
		f 2 corridor doors to the into its door frame. This			accomplished for those resider found to have been affected by		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155325	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	COMI	e survey Pleted 1/2023
	PROVIDER OR SUPPLIE	R AND REHABILITATION	900 AN	ADDRESS, CITY, STATE, ZIP CO ISON ST 1, IN 47167	.D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION DULD BE PROPRIATE	(X5) COMPLETION DATE
	REGULATORY Of deficient practice of staff and visitors. Findings include: Based on observation a.m. and 1:45 p.m. the Maintenance Staff and with a latter door frame. The domagnetic locking of Based on interview Maintenance Superkitchen corridor delatching device. This finding was resulted to the staff and visitors.			deficient practice: Residents did not have related to this alleged de practice. Kitchen door handle w replaced with a knob that into the door frame. How other residents have potential to be affected by same deficient practice identified and what correaction(s) will be taken: Residents have the pobe affected by the allege practice. Door knob replaced with handle that latches into frame. Image attached. What measures will be place and what systemic will be made to ensure the deficient practice does replaced of months with 2023 Audit Tool to ensure premeasures for latching domeet requirements. How the corrective action monitored to ensure the practice will not recur, it quality assurance prograput into place: Maintenance Director/definitions.	e ill effects e ill effects eficient as at latches ving the by the will be ective otential to ed deficient ith a the door put into c changes that the not recur: d monthly Life Safety eventative oor knobs on(s) will be e deficient e. what am will be	
				will conduct audits by incorporating an inspect Latching Door Handles in monthly OAPI Environm	into	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155325	r í	JILDING	nstruction 01	(X3) DATE COMPL 02/21/	ETED
	PROVIDER OR SUPPLIER	ND REHABILITATION		900 AN	ADDRESS, CITY, STATE, ZIP COD SON ST , IN 47167		
IVILABOV		NO KENNOLEN KITOK		O/ (LLIVI	,		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N BE PRIATE	(X5) COMPLETION DATE
					Checklist tool x 6 months. A noted audit tool results to be reviewed Monthly at QAPI meeting. If 95% compliance achieved, an action plan will implemented.	e is not	
					By what date the systemic changes will be completed: 3/22/2023		
					Kitchen Door: door knob wh latches into doorframe /p>	nich	
K 0741 SS=E Bldg. 01	shall include not le provisions: (1) Smoking shall ward, or comparte liquids, combustib used or stored and location, and such signs that read NC posted with the interest smoking. (2) In health care a smoking is prohibit prominently place secondary signs ware smoking shall not (3) Smoking by paresponsible shall to the requirement apply where the parent signs.	ns shall be adopted and less than the following be prohibited in any room, ment where flammable le gases, or oxygen is do in any other hazardous area shall be posted with D SMOKING or shall be ternational symbol for no occupancies where ted and signs are do at all major entrances, with language that prohibits be required.					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155325		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/21/2023		
	PROVIDER OR SUPPLIER	ND REHABILITATION	900 AN	ADDRESS, CITY, STATE, ZIP COD NSON ST M, IN 47167	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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
me	safe design shall be where smoking is (6) Metal contained devices into which shall be readily averaged smoking is permitted 18.7.4, 19.7.4 Based on observation failed to ensure cigar disposed of at 1 of 1	pe provided in all areas permitted. It is with self-closing cover a ashtrays can be emptied railable to all areas where sted. It is and interview, the facility arette butts were properly area where cigarettes were	K 0741	What corrective action(s) will accomplished for those reside found to have been affected be	be 03/22/2023 ents
	Findings include: Based on observation a.m. and 1:45 p.m. of the Maintenance Su	s. This deficient practice 5 residents and staff. ons on 02/21/23 between 11:45 during a tour of the facility with pervisor, Director of ment, and Executive Director,		deficient practice: • Residents did not have ill eff related to this alleged deficien practice. • Metal, red, self-closing cove devices replaced the plastic was receptacles in the smoking and thou other residents having the	r vaste ea.
	the resident smokin large plastic waste t with hundreds of ci- interview at the tim Maintenance Super	g area in the courtyard had a pasket full of paper trash mixed garette butts. Based on e of observation, the visor acknowledged the paper garette butts in the large plastic		potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: • Residents have the potentia be affected by the alleged def practice. • Plastic waste receptacles we	l to icient
	Supervisor, Directo and Executive Directo	viewed with the Maintenance r of Properties Management, etor during the exit conference.		replaced with metal, red, self-closing covered cans in the smoking area. Image attached	d.
	3.1-19(b)			What measures will be put int place and what systemic char will be made to ensure that the deficient practice does not receive. Maintenance Supervisor/designee will roun monthly for 6 months with 202 Life Safety Audit Tool to ensure only metal self-closing, covered.	nges e cur: d 23 re

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155325	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 02/21/2023	
NAME OF PROVIDER OR SUPPLIER MEADOW VIEW HEALTH AND REHABILITATION		900 AN	ADDRESS, CITY, STATE, ZIP COD ISON ST 1, IN 47167			
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE 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)	TE	(X5) COMPLETION DATE
				containers are used in smokin areas.	g	
				How the corrective action(s) we monitored to ensure the deficipractice will not recur, ie. what quality assurance program will put into place: Maintenance Supervisor/design will conduct audits by incorporating an inspection of smoking receptacles into mon QAPI Environmental Checklist x 6 months. All noted audit too results to be reviewed Monthly QAPI meeting. If 95% compliatis not achieved, an action plant be implemented.	ent t I be gnee thly t tool ol / at nce	
				By what date the systemic changes will be completed: 3/22/2023 Smoking: metal container with self-closing cover /p>	ı	

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