

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/01/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155325		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____		X3) DATE SURVEY COMPLETED 04/02/2024	
NAME OF PROVIDER OR SUPPLIER MEADOW VIEW HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP COD 900 ANSON ST SALEM, IN 47167			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 04/02/2024</p> <p>Facility Number: 000218 Provider Number: 155325 AIM Number: 100274800</p> <p>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</p> <p>The facility has a capacity of 98 certified beds and had a census of 69 at the time of this visit.</p> <p>Quality Review completed on 04/09/24</p>			E 0000			
K 0000 Bldg. 01	<p>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).</p> <p>Survey Date: 04/02/24</p> <p>Facility Number: 000218 Provider Number: 155325 AIM Number: 100274800</p> <p>At this Life Safety Code survey, Meadow View</p>			K 0000	<p>POC Meadow View Health & Rehabilitation</p> <p>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.</p> <p>This provider respectfully requests that this 2567 Plan of Correction</p>		

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

TITLE

(X6) DATE

Krista Smith

Executive Director

04/26/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosable 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/01/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155325		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 04/02/2024	
NAME OF PROVIDER OR SUPPLIER MEADOW VIEW HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 900 ANSON ST SALEM, IN 47167			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
K 0353 SS=B Bldg. 01	<p>Health and Rehabilitation Center was found in substantial 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.</p> <p>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 69 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered except one detached wood framed storage shed.</p> <p>Quality Review completed on 04/09/24</p> <p>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.</p> <p>a) Date sprinkler system last checked</p> <p>b) Who provided system test</p>				be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155325		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 04/02/2024	
NAME OF PROVIDER OR SUPPLIER MEADOW VIEW HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP COD 900 ANSON ST SALEM, IN 47167			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>c) Water system supply source</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.</p> <p>9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 sprinkler riser rooms. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect several staff and residents within the same smoke compartment as the sprinkler riser room.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Maintenance Director and Executive Director on 04/02/2024 between 10:37 AM and 12:34 PM, a penetration of 3/8 inches was observed in the ceiling of the sprinkler riser room. This room was equipped with sprinkler coverage. Based on interview at the time of the observations, the Maintenance Director agreed the penetration were present and provided the measurement of the penetration.</p> <p>These findings were reviewed with the Maintenance Director, Executive Director, and Senior Maintenance Supervisor at the exit conference.</p>			K 0353	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none">• Residents did not have ill effects related to this alleged deficient practice.• Noted penetration of 3/8 inches was repaired, image attached <p>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:</p> <ul style="list-style-type: none">• Residents have the potential to be affected by the alleged deficient practice.• Bolt was tightened until flush with ceiling fixture, and fireproof caulking was also applied <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none">• Smooth ceiling audit added to monthly inspections• Maintenance Supervisor/designee will round monthly using 2024 Life Safety Audit Tool to ensure smooth ceiling requirement is met.		04/26/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/01/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155325		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 04/02/2024	
NAME OF PROVIDER OR SUPPLIER MEADOW VIEW HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP COD 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
K 0511 SS=B Bldg. 01	3.1-19(b) NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 electrical light switch outlets in the lounge on the wall closest to the hallway was protected. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect at least 10 residents and staff near the north side nurse's station.			K 0511	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 ceiling conditions into the 2024 Life Safety Audit Tool. 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 were completed: 4.26.2024 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. • Switch cover was installed, image attached.		04/26/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/01/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155325		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 04/02/2024	
NAME OF PROVIDER OR SUPPLIER MEADOW VIEW HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP COD 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
	<p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director, Senior Maintenance Supervisor, and Executive Director on 04/02/2024 between 10:37 AM and 12:34 PM, the light switch cover in the north lounge on the wall closest to the hallway was missing a cover plate. Based on interview at the time of the observation, the Senior Maintenance Supervisor and Maintenance Director reported a resident handing them a coverplate earlier in the day and they were not able to find where the coverplate came from</p> <p>This finding was reviewed with the Maintenance Director, Senior Maintenance Supervisor, and the Executive Director at the exit conference.</p> <p>3.1-19(b)</p>				<p>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:</p> <ul style="list-style-type: none">• Residents have the potential to be affected by the alleged deficient practice.• Switch cover was installed. <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none">• Maintenance Supervisor/designee will round monthly using 2024 Life Safety Audit Tool to ensure outlet covers are intact and in place. <p>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:</p> <p>Maintenance Supervisor/designee will conduct monthly audits by incorporating outlet cover inspections into 2024 Life Safety Audit Tool. All noted audit tool results to be reviewed Monthly at QAPI meeting. If 95% compliance is not achieved, an action plan will be implemented.</p> <p>By what date the systemic changes were completed:</p> <p>4.26.2024</p>		