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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	ETED
		155253	B. W	NG		10/15/	2019
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				AMARACK TRAIL		
MEADOW	VOOD HEALTH PA	VILION			MINGTON, IN 47408		
IVIEADOV	VOOD REALTH PA	VILION		BLOOK	IINGTON, IN 47406		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID BROWINER'S BLANCE COR			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
E 0000							
Bldg							
	An Emergency Prep	paredness Survey was	E 0	000	By submitting the enclosed		
		diana State Department of		300	material we are not admitting t	he	
	Health in accordance with 42 CFR 483.73.				truth or accuracy of any specif		
					findings or allegations. We res		
	Survey Date: 10/15	5/19			the right to contest the findings		
					allegations as part of any	. J.	
	Facility Number: 0	00156			proceedings and submit these		
	Provider Number:				responses pursuant to our		
	AIM Number: 3000				regulatory obligations. The fac	rility	
	THIN I VAINOUT. 5000	2113)			requests that the plan of	Jiirty	
	At this Emergency I	Preparedness survey,			correction be considered our		
		Pavilion was found in			allegation of compliance effect	rivo	
		nergency Preparedness			November 14th, 2019 to the	ive	
		Iedicare and Medicaid			annual licensure survey condu	uctod	
		lers and Suppliers, 42 CFR			on October 15th, 2019. We	icieu	
	483.73	iers and Suppliers, 42 Cr K			respectfully request a paper		
	403.73				review. We will provide you		
	The facility has a co	pacity of 66 certified beds and			with any additional informati	.	
	-	at the time of this visit.			to confirm compliance per yo		
	nau a census or 49 a	it the time of this visit.				ui	
	Quality Review con	anlated on 10/19/10			request.		
	Quality Keview con	iipieted oii 10/18/19					
K 0000							
10000							
Bldg. 01							
Diag. 01	Δ Life Safety Code	Recertification and State	K 0	000	By submitting the enclosed		ı
	•	ras conducted by the Indiana	KU	000	material we are not admitting t	ho	
	•	f Health in accordance with 42			_		
	CFR 483.90(a).	Health in accordance with 42			truth or accuracy of any specif		
	CFK 465.90(a).				findings or allegations. We res		
	Survey Date: 10/15	7/10			the right to contest the findings	S OI	
	Survey Date. 10/13	// 17			allegations as part of any		
	Facility Number 0	00156			proceedings and submit these		
	Facility Number: 0				responses pursuant to our	sili4s :	
	Provider Number: 1				regulatory obligations. The fac	cility	
	AIM Number: 3000	J2 44 3 9			requests that the plan of		
	A A Albin Tile College	Cada sumusu Maada aa 1			correction be considered our		
	At this Life Safety (Code survey, Meadowood			allegation of compliance effect	ive	
					I.		ا

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

TITLE

(X6) DATE

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.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155253	B. WI	ING		10/15/	/2019
NAME OF T	MOLUDED OF GUMPY TO			STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF P	PROVIDER OR SUPPLIEF	X		2455 T/	AMARACK TRAIL		
MEADOV	VOOD HEALTH PA	AVILION		BLOOMINGTON, IN 47408			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		s found not in compliance with			November 14th, 2019 to the		
	_	Participation in Medicare, 42			annual licensure survey cond	ucted	
	•	0(a), Life Safety from Fire and			on October 15th, 2019. We		
		the National Fire Protection			respectfully request a paper		
		1) 101, Life Safety Code (LSC),			review. We will provide you		
	-	g Health Care Occupancies and			with any additional informat		
	410 IAC 16.2.				to confirm compliance per y	our	
	This one story for all	ity was determined to be of			request.		
	-	lity was determined to be of					
	Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and all areas open to the corridor, plus battery powered smoke alarms in all resident sleeping rooms. The facility has a capacity of 66 and had a census of 49 at the						
	time of this survey.						
	time of tims survey.						
	All areas where res	idents have customary access					
	were sprinklered. A	All areas providing facility					
	services were sprin	klered.					
	Quality Review cor	mpleted on 10/18/19					
K 0100	NFPA 101						
SS=F	General Requiren	nents - Other					
Bldg. 01	General Requiren						
	· ·	RKS section any LSC					
		19.1 General Requirements					
		essed by the provided					
		eficient. This information,					
	-	olicable Life Safety Code or					
	NFPA standard ci	itation, should be included					
	on Form CMS-250	67.					
	Based on record rev	view, observation and	K 0	100	By submitting the enclosed		11/14/2019
	interview; the facili	ity failed to provide complete			material we are not admitting	the	
		the preventative maintenance			truth or accuracy of any speci		
	of 47 of 47 battery	powered smoke alarms in			findings or allegations. We res		
	-	FPA 101 in 4.6.12.3 states			the right to contest the finding		
	existing life safety	features obvious to the public,			allegations as part of any		
	-	he Code, shall be maintained.			proceedings and submit these	9	

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T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155253	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION <u>01</u>	(X3) DATE SURVEY COMPLETED 10/15/2019
ROVIDER OR SUPPLIER		2455 T	ADDRESS, CITY, STATE, ZIP COD AMARACK TRAIL MINGTON, IN 47408	
SUMMARY S (EACH DEFICIEN REGULATORY OR This deficient practistaff, and visitors. Findings include: Based on record reva.m. and 12:15 p.m. present, the facility documentation of a (PM) program for the powered smoke alardocumentation shows moke alarms were basis. The most recovere in February an interview at the time Maintenance Direct all battery powered be tested on a month observations between during a tour of the Director, all residen	VILION STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION ce could affect all residents, iew on 10/15/19 between 9:15 with the Maintenance Director was able to provide preventative maintenance he testing of all battery rms, however, the wed that the battery powered only tested on a semi annual ent two inspections/tests d August of 2019. Based on e of record review, the or said he was not aware that smoke alarms were required to	STREET 2 2455 TA	AMARACK TRAIL	(X5) COMPLETION DATE cility tive acted on our ty cy cc a for ctice red as.
			Other residents that have the potential to be affected have been identified by: Residents had the potential to affected. None were identified The measures or systematic changes that have been put	b be

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED			LETED	
		155253	B. W	ING		10/15	
		100000			_		
NAME OF P	PROVIDER OR SUPPLIEF	Ł			ADDRESS, CITY, STATE, ZIP COD		
					AMARACK TRAIL		
MEADOV	VOOD HEALTH PA	VILION		BLOOM	MINGTON, IN 47408		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DE CAMPANA DA LA CAPACITACIÓN		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	•	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.IE	DATE
					place to ensure that the		
					deficient practice does not r	ecur	
					include:		
					Maintenance Staff has been		
					in-serviced on Preventative		
					Maintenance and documentat	ion	
					of battery powered smoke ala		
					in resident rooms.		
					The corrective action taken	to	
					monitor performance to ass		
					compliance through quality	ui C	
					assurance is:		
					A Performance Improvement	Tool	
					has been initiated that random		
					observes battery powered sm	-	
					detector testing and	OKC	
					documentation in resident roo	me	
					The Director of Maintenance of		
					designee, will complete this to		
					weekly x3, monthly x3, then	OI .	
					quarterly x3. Any issues obse	nyad	
					out of compliance, re-education		
					will be initiated. The Quality) I I	
					Assurance Committee will rev	iow	
					the tools at the scheduled	iew	
						no	
					meetings with recommendation		
					as needed based on the outco	ines	
					of the tools.		
					The date the systemic chang		
					will be completed: November	ŧr	
					14th, 2019		
K 0131	NFPA 101						
SS=F		cios					
Bldg. 01	Multiple Occupan						
Blug. UT	· ·	cies - Sections of Health					
	Care Facilities	and facilities along if and an					
		care facilities classified as					
	other occupancies	s meet all of the following:					
			1		Ī		I

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o They are not intended to serve four or

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SU		SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155253	B. WI	NG		10/15/2019	
NAME OF T	DOLUMED OF GURES TO			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	К		2455 T	AMARACK TRAIL		
MEADOV	WOOD HEALTH PA	AVILION		BLOOM	MINGTON, IN 47408		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		or purposes of housing,					
	treatment, or customary access. o They are separated from areas of health						
	care occupancies						
	I	aving a minimum two hour					
	fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance						
	with Section 9.7.						
	Hospital outpatient surgical departments are						
	required to be cla	ssified as an Ambulatory					
		ipancy regardless of the					
	number of patient						
		482.41, 42 CFR 485.623					
		ation and interview, the facility	K 0	131	K131 Multiple Occupancies		11/14/2019
		he two-hour rated construction			It is the practice of this facil	-	
	_	ancy separation wall. LSC			to maintain the two-hour rat		
		rations for cables, cable trays,			construction of fire occupar	ıcy	
		ses, combustion vents and similar items to			separation walls without		
	1	rical, mechanical, plumbing,			penetrations and it is also the practice of this facility to	IE	
		ns systems that pass through a			ensure that the 90 minute ra	ted	
		/ceiling assembly constructed			fire doors close and latch	.cu	
	1	Il be protected by a firestop			properly.		
		The firestop system or device			The correction action taken	for	
	l ⁻	ccordance with ASTM E 814,			those residents found to be		
	Standard Test Meth	nod for Fire Tests of Through			affected by the deficient pra	ctice	
		ops, or ANSI/UL 1479,			include:		
		ests of Through- Penetration			1.Teachable Moments		
		mum positive pressure			conducted for Maintenance		
		in. water column (2.5 N/m2)			Director for unsealed penetra	tions	
	between the exposed and the unexposed surface				where electrical conduit		
	· ·	y. 8.3.5.2 states where the			penetrated the two hour fire w		
		es a sleeve to penetrate the			and fire doors not closing and	I	
	1	eeve shall be securely set in the			latching appropriately.		
		he space between the item and			2.Penetrations separating the		
	me sieeve snaii be	filled with a material that	ı		skilled unit from the IL unit Se	aiea.	I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 10/15/2019 155253 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2455 TAMARACK TRAIL BLOOMINGTON, IN 47408 MEADOWOOD HEALTH PAVILION (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE complies with 8.3.5.1. This deficient practice 3. Fire Door Closures between could affect all residents, as well as staff and Maintenance service hall on visitors. skilled side and the IL kitchen side, adjusted to close and latch Findings include: properly. Other residents that have the Based on observation on 10/15/19 at 1:25 p.m. potential to be affected have during a tour of the facility with the with the been identified by: Maintenance Director, the two hour fire wall Residents had the potential to be separating the skilled unit from the assisted living affected. None were identified. unit had at least five unsealed penetrations The measures or systematic ranging in size from two inches to one and a half changes that have been put into feet where electrical conduits penetrated the two place to ensure that the hour fire wall. Based on interview at the time of deficient practice does not recur observation, the Maintenance Director agreed include: there were unsealed penetrations in the fire wall Maintenance Staff has been that separated the skilled unit from the assisted in-serviced on maintaining fire living and said he was unaware the unsealed occupancy separation walls penetrations existed. without penetrations and on Fire doors closing and latching 3.1-19(b) properly. The corrective action taken to 2. Based on observation and interview, the monitor performance to assure facility failed to ensure 1 of 2 sets of fire doors in a compliance through quality 2 hour separation wall between the skilled unit assurance is: and the assisted living unit was maintained. LSC A Performance Improvement Tool 8.3.3.1 states openings required to have a fire has been initiated that randomly protection rating of 1 1/2 hour in a 2 hour fire wall reviews 5 separation walls for or partition shall be protected by approved, listed, penetrations and 5 sets of fire labeled fire door assemblies and fire window doors for proper closure and assemblies and their accompanying hardware, latching. The Maintenance including all frames, closing devices, anchorage, Director, or designee, will and sills in accordance with the requirements of complete this tool weekly x3, NFPA 80, Standard for Fire Doors and Other monthly x3, and quarterly x3. Any Opening Protectives. 8.3.3.2.2 states all products issues identified will be required shall bear an approved label. This immediately corrected. The deficient practice could affect all residents, as well **Quality Assurance Committee will** as staff and visitors. review the tool at the scheduled meetings with recommendations Findings include: for additional interventions as

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	OF CORRECTION	IDENTIFICATION NUMBER 155253	A. BUILDING B. WING	01	COMPLETED 10/15/2019
	ROVIDER OR SUPPLIER		2455 T	ADDRESS, CITY, STATE, ZIP COD AMARACK TRAIL MINGTON, IN 47408	
(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 I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N (X5) SEE COMPLETION DATE
	during a tour of the Director, the set of between the mainter skilled unit side and assisted living unit s and latch when teste one half inch gap be fully. Based on inte observation, the Ma set of 90 minute fire when tested several the doors were not constituted.	intenance Director agreed the doors did not close and latch times and said he didn't know		needed based on review of outcomes of the PI tool. The date the systemic chawill be completed: November 14, 2019	nges
K 0321 SS=E Bldg. 01	barrier having 1-hd (with 3/4 hour fire automatic fire extir accordance with 8 approved automat option is used, the from other spaces partitions and door Doors shall be self automatic-closing nonrated or field-a do not exceed 48 if the door.	reprotected by a fire pur fire resistance rating rated doors) or an anguishing system in areas shall be separated by smoke resisting rating in accordance with 8.4. Felosing or and permitted to have pplied protective plates that inches from the bottom of			

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	LETED	
		155253	B. W	ING		10/15	/2019	
NAME OF T	DROMDED OF GURBLIEF		1	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	X.			AMARACK TRAIL			
MEADO	WOOD HEALTH PA	VILION		BLOOM	MINGTON, IN 47408			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL PLICE IDENTIFYING INFORMATION		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG	Separation	R LSC IDENTIFYING INFORMATION	+	TAG			DATE	
	•	-Fired Heater Rooms						
	b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops							
		ooms (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 K32		K ₀	221	K321 Hazardous Areas		11/14/2010	
	Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous areas was		K 0	321	It is the practice of this facili	tv	11/14/2019	
		egress corridor. This deficient			to ensure that hazardous are	-		
	_	et mostly staff and visitors			are separated from the egres			
	while in the service				corridor.			
					The correction action taken	for		
	Findings include:				those residents found to be			
					affected by the deficient pra-	ctice		
		on on 10/15/19 at 1:40 p.m.			include:			
		facility with the Maintenance			1.Teachable Moments			
	·	e at least 15 plastic totes filled			conducted for Maintenance			
		ween decorations along with ored in the service corridor.			Director and Activities Directo			
		at the time of observation, the			storing of supplies/tubs in service corridor.	vice		
		tor agreed the totes and other			Other residents that have the	e		
		stored in the service corridor			potential to be affected have			
		l be removed as soon as			been identified by:			
	possible.				Staff & Visitors had the potent	ial		
					to be affected. None were			
	3.1-19(b)				identified.			
					The measures or systematic			
					changes that have been put	into		
					place to ensure that the			
					deficient practice does not r	ecur		
					include:	havo		
					Maintenance & Activity Staff I been in-serviced on proper sto			
					of tubs and decoration supplie	-		

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		155253	B. W			10/15/	
	PROVIDER OR SUPPLIER		•	2455 TA	ADDRESS, CITY, STATE, ZIP COD AMARACK TRAIL IINGTON, IN 47408		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
					and keeping egress corridors clear. The corrective action taken monitor performance to assist compliance through quality assurance is: A Performance Improvement has been initiated that random reviews service corridor is clear and clear of storage items. The Maintenance Director, or designee, will complete this to weekly x3, monthly x3, and quarterly x3. Any issues ident will be immediately corrected. The Quality Assurance Committee will review the tool the scheduled meetings with recommendations for additional interventions as needed based review of the outcomes of the tool. The date the systemic change will be completed: November 14, 2019	Tool hly an he ol tified at al d on Pl	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System Maintenance Fire Alarm System Maintenance	-					
	in accordance with complying with the National Electric C National Fire Alarr	-					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155253	r í	JILDING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/15/2019
NAME OF P	ROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD AMARACK TRAIL	
MEADOV	VOOD HEALTH PA	VILION			MINGTON, IN 47408	<u>.</u>
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE
TAG		view and interview, the facility	K O	345	K345 Fire Alarm System-	11/14/2019
		of 1 fire alarm systems in	K U	343	Testing & Maintenance	11/14/2019
		FPA 72, as required by LSC 101			It is the practice of this facil	ity
	Sections 19.3.4.5.1 and 9.6. NFPA 72, Section				to maintain the fire alarm	
	14.3.1 states that unless otherwise permitted by				systems devices by visual	
	_	ctions shall be performed in			semi-annual fire alarm syste	em
	accordance with the schedules in Table 14.3.1, or				inspection.	
	more often if required by the authority having				The correction action taker	
	jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually:				those residents found to be	
	_				affected by the deficient pra include:	actice
	a. Control unit trouble signals b. Remote annunciators				1.Teachable Moment was	
	c. Initiating devices (e.g. duct detectors, manual				conducted with Maintenance	
	_	eat detectors, smoke detectors,			Director over inspection of fire	e
	etc.)	,			alarm system devices being	
	d. Notification appl	iances			completed on a semi-annual	
	e. Magnetic hold-op	oen devices			basis.	
	This deficient pract	ice could affect all occupants			2.Visual Fire Alarm System	
	in the facility.				devices Inspection completed	d.
					Other residents that have the	пе
	Findings include:				potential to be affected have	e
	D 1 1	10/15/101			been identified by:	
		view on 10/15/19 between 9:15			Residents had the potential to	
		with the Maintenance Director ntation could be provided			affected. None were identified	
		emi-annual fire alarm system			The measures or systematic changes that have been put	
		on interview at the time of			place to ensure that the	
	-	Maintenance Director said that			deficient practice does not	recur
		f the fire-alarm system's			include:	
	devices were not pe	erformed on a semi annual			Maintenance Staff has been	
	basis.				in-serviced on maintaining fire	e
					alarm system devices by mal	<u> </u>
	3.1-19(b)				sure systems are inspected of	on a
					semi-annual basis.	
					The corrective action taken	
					monitor performance to ass	
					compliance through quality assurance is:	
					A Performance Improvement	Tool
					has been initiated that randor	

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

PRINTED: 11/12/2019 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155253	B. W	ING		10/15/	2019
	PROVIDER OR SUPPLIER			2455 TA	ADDRESS, CITY, STATE, ZIP COD AMARACK TRAIL IINGTON, IN 47408		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF 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	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0353 SS=F Bldg. 01	Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location an a) Date sprinkler b) Who provided c) Water system	supply source RKS information on non-required or partial r system.			reviews Fire alarm system inspection reports. The Maintenance Director, or designee, will complete this to weekly x3, monthly x3, and quarterly x3. Any issues ident will be immediately corrected. The Quality Assurance Committee will review the tool the scheduled meetings with recommendations for additional interventions as needed based review of the outcomes of the tool. The date the systemic chang will be completed: November 14, 2019	at al d on Pl	

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

Event ID:

PB2K21

Facility ID: 000156

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	01	COMPLETED	
		155253	B. W	ING		10/15/2019	
				STREET .	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			AMARACK TRAIL		
MEADOV	VOOD HEALTH PA	VILION	BLOOMINGTON, IN 47408				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF 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	COMPLETIC	ON
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		review, observation and	K 0	353	K353 Sprinkler Systems-	11/14/20	119
	· ·	ty failed to provide complete			Maintenance & Testing		
	_	nkler system inspections were			It is the practice of this facili	ty	
		NFPA 25 for 1 of 1 dry			to ensure that automatic		
	sprinkler system, and 1 of 1 wet system. NFPA 25,				sprinkler and standpipe		
		spection, Testing, and			systems are inspected, teste	ed	
	Maintenance of Water-Based Fire Protection				and maintained.		
	Systems, 2011 Edition, Section 5.2.4.2 states				The correction action taken	for	
	gauges on dry pipe sprinkler systems shall be				those residents found to be		
		ensure that normal air and			affected by the deficient pra	ctice	
		being maintained. Section			include:		
	5.2.4.1 states gauge	s on wet sprinkler systems			1.Teachable Moment condu	cted	
	shall be inspected n	nonthly to ensure that they are			with Maintenance Director		
	in good condition a	nd that normal water supply			regarding		
	pressure is being ma	aintained. Section 5.1.2 states			1.Weekly inspections of dry		
	valves and fire depa	artment connections shall be			sprinkler system gauges.		
	inspected, tested, ar	nd maintained in accordance			2.Monthly inspections of we	t	
	with Chapter 13. So	ection 13.1.1.2 states Table			sprinkler system gauges.		
	13.1.1.2 shall be uti	lized for inspection, testing and			3.Monthly inspections of		
	maintenance of valv	ves, valve components and			sprinkler system control valve	S.	
	trim. Section 4.3.1	states records shall be made for			1.Teachable Moment condu	cted	
		s, and maintenance of the			with Maintenance Director		
		ponents and shall be made			regarding replacement of spri	nkler	
		nority having jurisdiction upon			heads with corrosion. le Hskg		
		ient practice could affect all			closet and Spa.		
	residents, staff, and	visitors in the facility.			2.Teachable Moment condu	cted	
					with Maintenance Director		
	Findings include:				regarding Holes through ceilin	g in	
					wheelchair storage had		
		view on 10/15/19 between 9:15			penetrations not properly fire		
	•	with the Maintenance Director			stopped and missing ceiling ti		
	*	locumentation available			in Maintenance Directors office	-	
		inspections were performed on			3.Dry Sprinkler system gaug	•	
		06/21/19 and 09/03/19. Weekly			wet sprinkler system gauges a		
	dry sprinkler systen				Sprinkler system control valve	es	
		48 of the most recent 52 week			were inspected.		
	_	lable for review for the dry			4.Sprinkler heads in		
		urthermore, monthly wet			Housekeeping closet and spa		
		uge inspection documentation			were replaced.		
	for 8 of the most red	cent 12 month period was also			5.Penetrations in wheelchai	r	

11/12/2019 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 10/15/2019 155253 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2455 TAMARACK TRAIL MEADOWOOD HEALTH PAVILION **BLOOMINGTON, IN 47408** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE not available for review for the wet sprinkler storage were properly filled. system. In addition, monthly inspection 6.Ceiling tiles in Maintenance documentation for the sprinkler system control office replaced. valves for 8 months of the most recent 12 month Other residents that have the period was also not available for review. Based potential to be affected have on interview at the time of record review, the been identified by: Maintenance Director indicated the facility Residents had the potential to be performs regular visual sprinkler system affected. None were identified. inspections but does not have sprinkler system The measures or systematic gauge and control valve inspection changes that have been put into documentation for the past 12 months available place to ensure that the for review. Based on observations with the deficient practice does not recur Maintenance Director during a tour of the facility include: from 12:15 p.m. to 2:15 p.m. the facility had a total Maintenance Staff has been of 5 gauges between the two sprinkler risers. in-serviced on maintaining Weekly inspections of dry sprinkler 3.1-19(b) system gauges, Monthly inspections of wet sprinkler 2. Based on observation and interview, the system gauges, Monthly facility failed to ensure 2 of over 500 sprinkler inspections of sprinkler system heads in the facility were free of corrosion. NFPA control valves. Maintenance Staff 25, Standard for the Inspection, Testing, and has been in-service regarding Maintenance of Water-Based Fire Protection replacing sprinkler heads with Systems at 5.2.1.1.1 requires sprinklers to be free corrosion, properly fire stopping of paint and corrosion. 5.2.1.1.2 requires any penetrations in fire walls and sprinkler that shows signs of paint or corrosion replacing missing ceiling tiles. shall be replaced. This deficient practice could The corrective action taken to affect one resident and staff. monitor performance to assure compliance through quality Findings include: assurance is: A Performance Improvement Tool Based on observations on 10/15/19 between 12:15 has been initiated that randomly p.m. and 2:15 p.m. during a tour of the facility with reviews documentation of dry the Maintenance Director, the following was sprinkler system gauges weekly noted: inspections, wet sprinkler system a. There was one sprinkler head in the gauges monthly inspections and Housekeeping closet covered with green sprinkler system control valves corrosion. monthly inspections, sprinkler b. There was one sprinkler head in the SPA head inspections and

covered with green corrosion.

PB2K21

replacement, and missing ceiling

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	01	COMPL	
		155253	B. W	ING		10/15/	2019
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	S.			AMARACK TRAIL		
MEADOV	VOOD HEALTH PA	VILION			IINGTON, IN 47408		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG				TAG	DEFICIENCY)		DATE
	Based on interview				tiles. The Maintenance Direc		
		intenance Director agreed the			or designee, will complete this	tool	
	-	e covered with green			weekly x3, monthly x3, and		
	corrosion.				quarterly x3. Any issues ident	ified	
	2.1.10(1.)				will be immediately corrected.		
	3.1-19(b)				The Quality Assurance	ot.	
	3 Raced on obcome	ation and interview, the			Committee will review the tool	al	
		sure the ceiling in 2 of 8			the scheduled meetings with recommendations for additional	al	
	-	compartments was maintained			interventions as needed based		
		eads to function to their full			review of the outcomes of the		
	-	ficient practice could affect			tool.		
	over 10 residents, as well as staff and visitors.				The date the systemic chang	ies	
					will be completed: Novembe		
	Findings include:				14, 2019		
	C				,		
	Based on observation	ons on 10/15/19 between 12:15					
	p.m. and 2:15 p.m. o	during a tour of the facility with					
	the Maintenance Di	rector, the following was					
	noted:						
		holes through the ceiling					
		air storage closet across from					
		at ranged in size from one half					
		ound conduit penetrations that					
	were not properly fi						
		missing ceiling tiles in the					
	Maintenance Direct						
		dged by the Maintenance					
	Director at the time	of each observation.					
	3.1-19(b)						
	- (-)						
K 0511	NFPA 101						
SS=F	Utilities - Gas and	Electric					
Bldg. 01	Utilities - Gas and	Electric					
	Equipment using of	gas or related gas piping					
	complies with NFF	PA 54, National Fuel Gas					
		iring and equipment					
	•	PA 70, National Electric					
	Code. Existing ins	tallations can continue in					

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	COMPLETED		
		155253	B. W	ING		10/15/2019	
	DROLUDED OF STATE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	(AMARACK TRAIL		
MEADO	WOOD HEALTH PA	VILION	_	BLOOM	/INGTON, IN 47408		
(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 APPROPRIA DEFICIENCY)	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY	DATE	
	service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2						
		ation and interview, the	IZ O	<i>5</i> 1 1	K511 Utilities	11/14/2010	
		sure 1 of over 10 wet locations	K 0	311		11/14/2019	
	-	ground fault circuit interrupter			It is the practice of this facili to ensure that ground fault	lty	
		against electric shock. NFPA			circuit interrupters for		
		ion at 210.8 Ground-Fault			protection against electric		
	-	Protection for Personnel,			shock, are provided to wet		
	-	circuit-interruption for			locations, switch covers and	1	
	_	provided as required in			ceiling tiles are present and		
	210.8(A) through (C). The ground-fault				good repair and Electric pan		
	circuit-interrupter shall be installed in a readily				in facility corridors are locke		
	accessible location.				The correction action taken		
	Informational Note: See 215.9 for ground-fault				those residents found to be		
	circuit interrupter protection for personnel on				affected by the deficient pra		
	feeders.				include:		
	(B) Other Than Dw	relling Units. All 125-volt,			1.Teachable Moment was		
	single-phase, 15- ar	nd 20-ampere receptacles			conducted with Maintenance		
	installed in the loca	tions specified in 210.8(B)(1)			Director over electric receptac	cle	
	through (8) shall ha	ve ground-fault			with no GFCI protection in soi	led	
	circuit-interrupter p	rotection for personnel.			utility, replacing missing light		
	(1) Bathrooms				switch covers, and keeping		
	(2) Kitchens				electrical panels in corridors		
	(3) Rooftops				locked.		
	(4) Outdoors				2.GFCI protection added to		
	_	(3) and (4): Receptacles that are			receptacle in soiled utility.		
		ele and are supplied by a			3.Switch cover placed on do	ouble	
		cated to electric snow-melting,			light switch in soiled utility.		
	O	and vessel heating equipment			4.Electric Panels in Corridor		
	-	o be installed in accordance			locked.		
	with 426.28 or 427.				Other residents that have th		
	_	(4): In industrial establishments			potential to be affected have	9	
	• .	ditions of maintenance and			been identified by:	ha	
	^	that only qualified personnel			Residents had the potential to		
		sured equipment grounding			affected. None were identified		
		as specified in 590.6(B)(2) or only those receptacle			The measures or systematic		
	_	or only those receptacte oly equipment that would			changes that have been put	IIILO	
		ard if power is interrupted or			place to ensure that the deficient practice does not r	rocur	
	-	t is not compatible with GFCI			include:	ecui	
	I naving a uesign tha	i is not compandic with GFCI	1		mciaae.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COM			COMPL	ETED
		155253	B. W	ING		10/15	/2019
		<u> </u>		CTD FET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8					
MEADON		VILION	2455 TAMARACK TRAIL				
IVIEADOV	VOOD HEALTH PA	VILION		BLOOK	MINGTON, IN 47408		
(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	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	protection.				Maintenance Staff has been		
	* *	eceptacles are installed within			in-serviced on GFCI protection	า	
		outside edge of the sink.			specifically in wet locations,		
	-	(5): In industrial laboratories,			replacing missing light switch		
	-	supply equipment where			covers, and keeping electrical		
	_	vould introduce a greater			panels in corridors locked.		
		nitted to be installed without			The corrective action taken to		
	GFCI protection.				monitor performance to assi	ure	
		(5): For receptacles located in			compliance through quality		
	-	s of general care or critical			assurance is:		
	care areas of health care facilities other than those				A Performance Improvement		
	covered under				has been initiated that random	-	
	210.8(B)(1), GFCI protection shall not be required.				reviews light switch covers on		
	(6) Indoor wet locat				in good repair, GFCI protectio		
		vith associated showering			receptacles when appropriate		
	facilities				fire panels in facility corridors	are	
		e bays, and similar areas where			locked. The Maintenance		
	electrical				Director, or designee, will		
		nt, electrical hand tools.			complete this tool weekly x3,		
		Vet Locations, requires all			monthly x3, and quarterly x3.	Any	
	-	ed equipment within the area of			issues identified will be		
		have ground-fault circuit			immediately corrected. The		
		protection. Note: Moisture can			Quality Assurance Committee		
		esistance of the body, and			review the tool at the schedule		
		is more subject to failure.			meetings with recommendatio	ns	
	-	ice could affect one or two			for additional interventions as	_	
	staff.				needed based on review of the	е	
	Findings to 1 1				outcomes of the PI tool.		
	Findings include:				The date the systemic chang		
	Događ om atazam seti	on on 10/15/10 at 12:56			will be completed: Novembe	r	
		on on 10/15/19 at 12:56 p.m.			14, 2019		
		facility with the Maintenance					
		Utility Room had one electric					
	receptacles on the wall within two feet of the hopper sink that was not provided with GFCI protection. This was confirmed when the						
	-						
receptacle was tested with a GFCI testing device. This was acknowledged by the Maintenance							
Director at the time of observation.		l					

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Event ID:

PB2K21

Facility ID: 000156

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		` ′				(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER					ETED
		155253	B. W	ING		10/15/	/2019
	PROVIDER OR SUPPLIER		•	2455 TA	ADDRESS, CITY, STATE, ZIP COD AMARACK TRAIL IINGTON, IN 47408	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	·	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE	DATE
	3.1-19(b)						
	2. Based on observ	ation and interview, the					
	1	sure a light switch in 1 of 8					
		ts was protected. NFPA 70,					
		le 406.6, Receptacle Faceplates					
		nires receptacle faceplates shall					
		completely cover the opening					
	_	mounting surface. This					
	deficient practice co	ould affect one or two staff.					
	Findings include:						
	Based on observation on 10/15/19 at 12:57 p.m.						
		facility with the Maintenance					
	_	e light switch cover was					
		ed Utility Room. Based on					
	_	e of observation, the					
		or acknowledged the cover					
	was missing on the	double light switch in the					
	Soiled Utility Roon	n and said he would put a new					
	cover on as soon as	possible.					
	3.1-19(b)						
	3. Based on observ	ation and interview, the					
		sure 10 of 10 electrical panels					
	1	ridors were secured from					
		sonnel. NFPA 70, 2011 edition					
	_	ized parts of service equipment					
	_	specified in 230.62(A) or					
	guarded as specified	•					
		gized parts shall be enclosed					
		t be exposed to accidental					
		guarded as in 230.62(B).					
	(B) Guarded. Energ	ized parts that are not enclosed					
	shall be installed on	a switchboard, panelboard, or					
	control board and g	uarded in accordance with					
	_	Where energized parts are					
	guarded as provided in $110.27(A)(1)$ and $(A)(2)$, a						

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PB2K21 Facility ID: 000156

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155253		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/15/2019		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2455 TAMARACK TRAIL BLOOMINGTON, IN 47408			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
	access to energized	parts shall be provided. This ould affect all residents, staff				
	12:15 p.m. and 2:15 facility with the Ma electrical panels in tunlocked when tested breakers to a variety on interview at the talenth Maintenance Direct in the corridors need would lock them but	ations on 10/15/19 between 5 p.m. during a tour of the intenance Director, ten the facility's corridors were ed. The panels included of of items in the facility. Based time of each observation, the or agreed the electrical panels d to be locked and said he t keys have to be made first for irrently on the panel.				
K 0761 SS=F Bldg. 01	Based on observation interview; the facilities inspection and testing fire rated door assers separation wall, and	on, record review, and ty failed to ensure an annual ng of 2 of 2 sets of 90 minute mblies within a two hour fire I one oxygen transfilling room d in accordance with LSC	K 0761	K761 Maintenance/Inspection Testing- Doors It is the practice of this facilit to ensure that Fire Doors assemblies are inspected an tested annually.	ty	
	19.1.1.4.1.1. Comn fire barriers required permitted only in coby approved self-cle (See also Section 8. required to have a fi 8.3.4.2 shall be prot labeled fire door assassemblies and their	nunicating openings in dividing d by 19.1.1.4.1 shall be orridors and shall be protected osing fire door assemblies. 3.) LSC 8.3.3.1 Openings ire protection rating by Table ected by approved, listed, semblies and fire window r accompanying hardware, s, closing devices, anchorage,		The correction action taken those residents found to be affected by the deficient practinclude: 1. Teachable Moment was conducted with Maintenance Director to ensure that Fire Do Assemblies are inspected annually. 2. Fire Door Assemblies	ctice	

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Event ID:

PB2K21 Fa

Facility ID: 000156

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 01	X3) DATE SURVEY COMPLETED		
		155253	B. WING		10/15/2019		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2455 TAMARACK TRAIL BLOOMINGTON, IN 47408				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION			
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
		nce with the requirements of		Inspected.			
	-	l for Fire Doors and Other		Other residents that have the	•		
		s, except as otherwise		potential to be affected have			
	-	de. NFPA 80 5.2.1 states fire		been identified by:			
		all be inspected and tested not		Residents had the potential to			
	-	and a written record of the		affected. None were identified	l.		
	_	signed and kept for inspection		The measures or systematic			
by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly.			changes that have been put i	into			
			place to ensure that the				
			deficient practice does not re	ecur			
			include:				
			Maintenance Staff has been	,			
	NFPA 80, 5.2.4.2 states as a minimum, the			in-serviced on annual inspection	on of		
	following items sha			fire door assemblies.			
		or breaks exist in surfaces of		The corrective action taken t			
	either the door or fr			monitor performance to assu	ire		
		light frames, and glazing beads		compliance through quality			
		rely fastened in place, if so		assurance is:	I		
	equipped.	hingag hardware		A Performance Improvement 1			
		e, hinges, hardware, and		has been initiated that random	ıy		
		reshold are secured, aligned,		reviews Fire Door Assemblies	200		
		er with no visible signs of		inspections for annual complia			
	damage. (4) No parts are mis	ssing or broken		The Maintenance Director, or			
		s do not exceed clearances		designee, will complete this too	UI .		
	listed in 4.8.4 and 6			weekly x3, monthly x3, and quarterly x3. Any issues ident	ified		
		g device is operational; that is,		will be immediately corrected.	illed		
		apletely closes when operated		The Quality Assurance			
	from the full open p			Committee will review the tool	at		
		is installed, the inactive leaf		the scheduled meetings with	at		
	closes before the ac			recommendations for additiona	al l		
		are operates and secures the		interventions as needed based			
	door when it is in the	-		review of the outcomes of the			
		•		tool.			
(9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or			The date the systemic chang	es			
	frame.	and the door of		will be completed: November			
		fications to the door assembly		14, 2019			
	` ′	ed that void the label.		17, 2010			
		edge seals, where required, are					

inspected to verify their presence and integrity.

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

PRINTED: 11/12/2019 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155253			UILDING	nstruction <u>01</u>	(X3) DATE (COMPL 10/15/	ETED	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2455 TAMARACK TRAIL BLOOMINGTON, IN 47408				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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 APPROPRIATE		(X5) COMPLETION DATE
	This deficient pract as well as staff and	ice could affect all residents, visitors.					
	Findings include:						
	a.m. and 12:15 p.m. present, the facility documentation for a inspection, includin rated separation documentation for a inspection, includin rated separation documentarion for separation transfilling room documentarion interview at the time Maintenance Direct regular fire door inscomputer based profail result and not a is produced. Based of the facility with the between 12:15 p.m. sets of 90 minute fire assemblies within a and the oxygen transembly. Furtherm fire doors between the on the skilled unit son the assisted livin completely and late	with the Maintenance Director was unable to provide an annual fire door assembly getwo sets of 90 minute fire or assemblies within a two wall, and the oxygen per assembly. Based on the of record review, the tor said the facility does do a spection through their peram, but it is only a pass or detailed inspection report that to no observations during a tour the Maintenance Director and 2:15 p.m., there were two re rated separation door two hour fire separation wall, asfilling room fire door more, the set of 90 minute rated the maintenance service hall and the kitchen service hall and unit side did not close the when tested several times.					
K 0914 SS=F	NFPA 101 Electrical Systems	s - Maintenance and					
Bldg. 01	Testing Electrical Systems Testing	s - Maintenance and ceptacles at patient bed					

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Event ID:

PB2K21

Facility ID: 000156

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155253		(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION G <u>01</u>	(X3) DATE SURVEY COMPLETED 10/15/2019				
		ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2455 TAMARACK TRAIL BLOOMINGTON, IN 47408				
	(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	CROSS-REFERENCED TO THE APPROP	E COMPLETION		
		locations and when anesthesia is adminitial installation, Additional testing defined by docum Receptacles not lithese locations are exceeding 12 more (LIM), if installed, less than or equal the LIM test switch activates both visual LIM circuits with a manual test is per than or equal to 12 tested per 6.3.3.3 renovation to the Records are main associated repairs containing date, reresults. 6.3.4 (NFPA 99) Based on observation interview; the facili nonhospital-grade eresident room locat annually. NFPA 99 2012 Edition, Section to listed as hospital locations and in locations and i	re deep sedation or general inistered, are tested after replacement or servicing. is performed at intervals ented performance data. sted as hospital-grade at e tested at intervals not inths. Line isolation monitors are tested at intervals of to 1 month by actuating in per 6.3.2.6.3.6, which had and audible alarm. For utomated self-testing, this formed at intervals less 2 months. LIM circuits are 2 after any repair or electric distribution system. Itained of required tests and is or modifications, from or area tested, and on, record review and try failed to ensure all electrical receptacles in 47 of 47 ions were tested at least 0, Health Care Facilities Code on 6.3.4.1.3 states receptacles in 47 of 47 ions where deep sedation or a sadministered, shall be tested teeding 12 months. Ion 6.3.3.2, Receptacle Testing in the state of the shall be confirmed by the septacle shall be confirmed by	K 0914	K914 Electrical Systems Maintenance & Testing It is the practice of this facto ensure that non hospital grade electrical receptacle resident room locations are tested annually. The correction action take those residents found to be affected by the deficient princlude: 1.Teachable Moment conditions for Maintenance Director over annual testing and document of testing on non-hospital grelectrical receptacles in resimplements for more sidents. 2.47 resident room electrical	I s in e e e e e e e e e e e e e e e e e e		

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

Event ID:

PB2K21 Facility ID: 000156

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155253		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/15/2019
	PROVIDER OR SUPPLIER WOOD HEALTH PAVILION	2455 T	ADDRESS, CITY, STATE, ZIP COD FAMARACK TRAIL MINGTON, IN 47408	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include: Based on record review on 10/15/19 between 9:15 a.m. and 12:15 p.m. with the Maintenance Director present, there was no record of an annual test for each resident room electrical receptacle that was not a hospital-grade receptacle. Based on interview at the time of record review, the Maintenance Director said all of the electrical receptacles in resident rooms were not hospital-grade receptacles as far as he knew. He further said there was no record or documentation to show that annual testing per NFPA 99, Receptacle Testing requirements was met. Based on observations between 12:15 p.m. and 2:15 p.m. during a tour of the facility with the Maintenance Director, there were at least four to six electrical receptacles in each of the resident rooms. 3.1-19(b)		receptacles were tested and documentation completed. Other residents that have the potential to be affected have been identified by: Residents had the potential to affected. None were identified. The measures or systematic changes that have been put place to ensure that the deficient practice does not ninclude: Maintenance Staff has been in-serviced on proper testing a documentation of non-hospits grade electrical receptacles in resident room locations. The corrective action taken monitor performance to ass compliance through quality assurance is: A Performance Improvement has been initiated that randon reviews Annual non hospital gelectrical receptacles in reside room locations. The Maintens Director, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. issues identified will be immediately corrected. The Quality Assurance Committee review the tool at the schedul meetings with recommendation for additional interventions as needed based on review of the outcomes of the PI tool. The date the systemic change will be completed: November 14, 2019	e e e e e e e e e e e e e e e e e e e

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED			ETED	
		155253	B. WING 10/15/2019			2019	
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				AMARACK TRAIL		
MEADOW	VOOD HEALTH DA	VILION			IINGTON, IN 47408		
MEADOWOOD HEALTH PAVILION				BLOON	IINGTON, IN 47408		
(X4) ID	SUMMARY S	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 APPROPRI		ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0918	NFPA 101						
SS=C		s - Essential Electric Syste					
Bldg. 01	-	s - Essential Electric					
ŭ	System Maintenar						
	•	other alternate power					
	-	ated equipment is capable					
		ce within 10 seconds. If the					
		n is not met during the					
		ocess shall be provided to					
	•	his capability for the life					
		branches. Maintenance					
		generator and transfer					
	_	ormed in accordance with					
	NFPA 110.						
	Generator sets are	e inspected weekly,					
	exercised under lo	oad 30 minutes 12 times a					
	year in 20-40 day	intervals, and exercised					
	once every 36 mo	nths for 4 continuous hours.					
	Scheduled test un	der load conditions include					
	a complete simula	ted cold start and					
	automatic or manu	ual transfer of all EES					
	loads, and are cor	nducted by competent					
	personnel. Mainte	nance and testing of stored					
	energy power sou	rces (Type 3 EES) are in					
	accordance with N	IFPA 111. Main and feeder					
	circuit breakers ar	e inspected annually, and a					
	program for period	dically exercising the					
	components is est	ablished according to					
	•	iirements. Written records					
		nd testing are maintained					
	-	ole. EES electrical panels					
		arked, readily identifiable,					
	•	normal power circuits.					
		ssibility of damage of the					
		source is a design					
	consideration for r						
		(NFPA 99), NFPA 110,					
	NFPA 111, 700.10		,	0.1.0			
		riew and interview, the facility	K 09	918	K918 Electrical Systems-		11/14/2019
failed to ensure an annual fuel quality test was				Essential Electric Syste			

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Event ID:

PB2K21 Facility ID: 000156

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OMB NO. 0938-039 X3) DATE SURVEY STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 10/15/2019 155253 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2455 TAMARACK TRAIL BLOOMINGTON, IN 47408 MEADOWOOD HEALTH PAVILION (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE performed for 1 of 1 diesel powered generator. It is the practice of this facility NFPA 99, Health Care Facilities Code, 2012 Edition to ensure that Annual Fuel Section 6.5.4.1.1.2 states Type 2 EES (Essential quality testing is performed for Electrical System) generator sets shall be diesel powered generators. inspected and tested in accordance with Section The correction action taken for 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance those residents found to be shall be performed in accordance with NFPA 110, affected by the deficient practice Standard for Emergency and Standby Power include: Systems, 2010 Edition, Chapter 8. NFPA 110, 1.Teachable Moments Section 8.3.8 states a fuel quality test shall be conducted for Maintenance performed at least annually using tests approved Director for Annual testing and by ASTM standards. This deficient practice documentation of fuel quality for could affect all residents, as well as staff and the diesel generator. visitors. 2. Safe Care Contacted for completion of Fuel Quality Testing Findings include: for diesel generator. Other residents that have the Based on record review on 10/15/19 between 9:15 potential to be affected have a.m. and 12:15 p.m. with the Maintenance Director been identified by: present, no documentation of an annual fuel Residents had the potential to be quality test for the diesel generator was available affected. None were identified. for review. Based on interview at the time of The measures or systematic records review, the Maintenance Director stated changes that have been put into the facility does have a diesel generator but was place to ensure that the unaware of the fuel quality testing requirements. deficient practice does not recur include: 3.1-19(b) Maintenance Staff has been in-serviced on proper Annual Testing and documentation of fuel quality for diesel generators. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly reviews annual testing and documentation of fuel quality

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testing for the diesel generator. The Maintenance Director, or

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155253		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE COMPL 10/15	LETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2455 TAMARACK TRAIL				
MEADO	WOOD HEALTH PA	VILION	BLOOI	MINGTON, IN 47408			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipme Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemb assembled by qua the conditions of 1 the patient care vi non-PCREE (e.g., except in long-terr do not use PCREI meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care r other UL standard used with general cords are not used wiring of a structu temporarily are re	ent - Power Cords and ent - Power Cords and patient care vicinity are only	TAG	designee, will complete to weekly x3, monthly x3, a quarterly x3. Any issues will be immediately correct The Quality Assurance Committee will review that the scheduled meetings recommendations for addinterventions as needed review of the outcomes of tool. The date the systemic of will be completed: Novel 14, 2019	this tool and aidentified acted. e tool at with ditional based on of the PI	DATE	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 10/15/2019 155253 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2455 TAMARACK TRAIL BLOOMINGTON, IN 47408 MEADOWOOD HEALTH PAVILION (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility K 0920 K 920 Electrical 11/14/2019 failed to ensure power strips were not used as a **Equipment-Power Cords and** substitute for fixed wiring in two staff areas. LSC Extens 19.5.1.1 requires utilities to comply with Section It is the practice of this facility 9.1. LSC 9.1.2 requires electrical wiring and to ensure that power strips are equipment to comply with NFPA 70, National not used as a substitute for Electrical Code. NFPA 70, Article 400-8 requires, fixed wiring. unless specifically permitted, flexible cords and The correction action taken for cables shall not be used as a substitute for fixed those residents found to be wiring of a structure. This deficient practice could affected by the deficient practice affect at least 2 staff. include: 1.Teachable Moments Findings include: conducted for Maintenance Director, Administrator and ADON Based on observations on 10/15/19 between 12:15 for use of power strips in offices. p.m. and 2:15 p.m. during a tour of the facility with 2. Power Strips Removed the Maintenance Director, the following was 10/16/19. noted: Other residents that have the a. There was a microwave oven, small refrigerator, potential to be affected have and a coffee maker plugged into a power strip in been identified by: the Assistant DON office Residents had the potential to be b. There was a small refrigerator plugged into a affected. None were identified. power strip in the Administrator's office. The measures or systematic Based on interview at the time of each changes that have been put into observation, the Maintenance Director place to ensure that the acknowledged the use of the power strips in the deficient practice does not recur Assistant DON office and Administrator's office include: and said he was not aware the power strips were Maintenance Staff and being used. Administrative staff have been in-serviced on not using power 3.1-19(b) strips as a substitute for fixed wiring. The corrective action taken to monitor performance to assure compliance through quality assurance is:

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A Performance Improvement Tool

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155253		A. BUILDING B. WING	01	COMPLETED 10/15/2019	
	ROVIDER OR SUPPLIER		2455 T	ADDRESS, CITY, STATE, ZIP COD AMARACK TRAIL IINGTON, IN 47408	
(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
K 0923 SS=D Bldg. 01	Storag Gas Equipment - O Storage Greater than or eq Storage locations and ventilated in a and 5.1.3.3.3. >300 but <3,000 c Storage locations a enclosure or withir space of non- or lir construction, with a that can be secure stored with flamma from combustibles sprinklered) or enc noncombustible cominimum 1/2 hr. fit Less than or equal	are outdoors in an an enclosed interior mited- combustible door (or gates outdoors) and. Oxidizing gases are not ables, and are separated by 20 feet (5 feet if closed in a cabinet of construction having a re protection rating.		has been initiated that random reviews Offices for use of pow strips. The Maintenance Director designee, will complete this weekly x3, monthly x3, and quarterly x3. Any issues identically be immediately corrected. The Quality Assurance Committee will review the tool the scheduled meetings with recommendations for additional interventions as needed based review of the outcomes of the tool. The date the systemic change will be completed: November 14, 2019	rer ctor, s tool tified at al d on Pl

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED			
		155253	B. WING		_	10/15/2019		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD AMARACK TRAIL			
MEADOWOOD HEALTH PAVILION				BLOOMINGTON, IN 47408				
(X4) ID		STATEMENT OF DEFICIENCIE	PROVIDER'S		PROVIDER'S PLAN OF CORRECTION			
PREFIX	` `	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	(EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		+	TAG DEFICIENCY)			DATE	
	cylinders available for immediate use in							
	1 .	patient care areas with an aggregate volume						
	of less than or equal to 300 cubic feet are not							
	required to be stored in an enclosure.							
	Cylinders must be handled with precautions as specified in 11.6.2.							
	A precautionary sign readable from 5 feet is							
	on each door or gate of a cylinder storage							
	room, where the sign includes the wording as							
	a minimum "CAUTION: OXIDIZING GAS(ES)							
	STORED WITHIN	I NO SMOKING."						
	Storage is planne	d so cylinders are used in						
	order of which the	ey are received from the						
	supplier. Empty of	cylinders are segregated						
	1	. When facility employs						
	1 7	gral pressure gauge, a						
		e considered empty is						
	1	oty cylinders are marked to						
		Cylinders stored in the open						
	are protected from							
		.3.3, 11.3.4, 11.6.5 (NFPA						
	99)	on and interview the facility	17.0	022	022 Coo Familia mont Cultin do	_	11/14/2010	
		on and interview, the facility f 1 cylinder of nonflammable	K 0	923	923 Gas Equipment-Cylinder		11/14/2019	
		um tank was properly secured			and Container Storage It is the practice of this facilit	tv		
	_	A 99, Health Care Facilities			to ensure that cylinders of	·y		
	_	, Section 11.3.2 states storage			non-flammable gases such a	ıs		
		gases greater than 8.5 cubic			helium tanks are properly	•		
	_	eet) but less than 85 cubic			secured.			
	`	feet) shall comply with 11.3.2.1			The correction action taken	for		
		NFPA 99, Section 11.3.2.6 states			those residents found to be			
	cylinder or containe	er restraints shall comply with			affected by the deficient prac	ctice		
	11.6.2.3. Section 1	1.6.2.3(11) states freestanding			include:			
		roperly chained or supported			1.Teachable Moments			
		stand or cart. This deficient			conducted for Maintenance			
	practice could affect	et staff in the Activity office.			Director and Activity Staff for			
					helium tank not being properly			
	Findings include:				supported or secured from fall	•		
	Based on observation	on on 10/15/19 at 1:20 p.m.			2.Helium Tank Secured, cha re-attached.	ur1		
	Dasca on obscivati	011 011 10/13/17 at 1.40 p.111.	1		ו וט־מוומטווכט.		1	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING		(X3) DATE SURVEY COMPLETED		
155253		B. WING		10/15/2019			
	ROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 2455 TAMARACK TRAIL BLOOMINGTON, IN 47408				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE			ID	Ι	(X5)		
PREFIX		ICY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION		
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIATE			
1110	during a tour of the facility with the Maintenance		1110	Other residents that have the	DATE		
	_	s one large helium tank on the	potential to be affected have				
	floor in the Activity office which was not properly		been identified by: Residents had the potent				
	supported or secured from falling. Based on				be		
	interview at the time of observation, the		affected. None were ident				
	Maintenance Direct	tor acknowledged that the	The measures or system		:		
	helium tank was no	t secured properly to prevent		changes that have been put			
	the cylinder from falling.						
				deficient practice does not r	ecur		
	3.1-19(b)			include:			
				1.In-service conducted for			
				Maintenance Director and Act	•		
				Staff for helium tank not being			
				properly supported or secured	1		
				from falling			
			The corrective action taken to monitor performance to assure				
				compliance through quality			
			assurance is:				
				A Performance Improvement	Tool		
				has been initiated that random			
				reviews Offices for proper stor	-		
				of Helium tank. The Maintena	_		
				Director, or designee, will			
				complete this tool weekly x3,			
				monthly x3, and quarterly x3.	Any		
				issues identified will be	,		
				immediately corrected. The			
				Quality Assurance Committee	will		
				review the tool at the schedule	ed		
				meetings with recommendation	ns		
				for additional interventions as			
				needed based on review of th	e		
				outcomes of the PI tool.			
				The date the systemic chang			
			will be completed: Novembe	r			
				14, 2019			
			I	I	I		

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