

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/15/2014
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NAME OF PROVIDER OR SUPPLIER WATERS OF MUNCIE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 04/15/14</p> <p>Facility Number: 000310 Provider Number: 155443 AIM Number: 100288970</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, The Waters of Muncie was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 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 (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in spaces open to the corridors. The resident rooms have battery powered smoke detection. The facility has a capacity of 72 and had a census of 54 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas which provide facility services were sprinklered except for the one detached</p>	K010000		

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 14 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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K010018 SS=E	<p>garage used for facility storage, a smoking shed and the front entrance canopy.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/24/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following: NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 19 corridor doors on 100 hall south did not have a space at the bottom exceeding 1 inch and were smoke resistant. LSC 19.3.6.3 states the clearance between the bottom of the door and the floor covering shall not exceed 1 inch. This deficient practice could affect 24 residents on 100 hall south as well as visitors and staff.</p> <p>Findings include:</p>	K010018	<p>It is the intent of this facility to ensure all doors do not exceed a 1 inch opening on the bottom.</p> <ol style="list-style-type: none"> On 4/16/14, the door on the ice room on the 100 hall was replaced. All other doors were inspected to ensure doors did not exceed regulated measurements. 	04/16/2014	

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K010038 SS=E	<p>Based on observation on 04/15/14 at 1:00 p.m. with the Maintenance Supervisor, the door leading into the ice machine room on 100 hall south had a three and one half inch gap at the bottom of the door which would not prevent smoke from entering the exit corridor. Based on interview on 04/15/14 with the Maintenance Supervisor, it was acknowledged the aforementioned door was not smoke resistant.</p> <p>3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 3 of 16 nonresident rooms do not require the unlocking of two locks on the door to exit from a room. This deficient practice could affect 14 residents on the 100 hall and 8 residents observed in the dining room as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observations on 04/15/14 during the tour between 1:16 p.m. and 1:33 p.m. with the Maintenance Supervisor, the file room and the ice machine room doors, both adjacent to 100 hall, had a deadbolt lock and a knob lock. The employee lounge on Service hall was provided with an exit door to the outside for staff and visitors, however, there was a knob lock plus a key lock and latch which could not be unlocked without assistance from Maintenance who were the only ones with a key. Based on interview on 04/15/14 concurrent with the observations it</p>	K010038	<p>3. Maintenance supervisor will ensure that any doors replaced will be to regulated measurements.</p> <p>4. Maintenance supervisor will ensure that any doors replaced will be to regulated measurements.</p> <p>5. Corrected Date: 4/16/2014</p> <p>It is the intent of this facility to ensure non- resident rooms do not have two locks on the door to exit.</p> <p>1. On 4-16-14, a lock on three doors that was found to have double locks was removed, as to only provide one lock for each of these doors.</p> <p>2. The rooms affected, Medical Records, Ice Room, and Employee Break room are non-resident areas, and would not pose to be harmful for any residents.</p> <p>3. Maintenance will ensure that no locks in non-resident rooms exiting to the outside have double locks.</p> <p>4. Maintenance will ensure that if any doors are replaced, it does not</p>	04/16/2014			

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K010047 SS=E	<p>was acknowledged by the Maintenance Supervisor, the deadbolts on the file and ice machine room doors, and the lock and latch on the employee lounge exit door should be removed.</p> <p>3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1</p> <p>Based on observations and interview, the facility failed to provide directional signs for 1 of 12 exit discharge means of egress. LSC 7.7.3 requires the exit discharge shall be arranged and marked to make clear the direction of egress to a public way. This deficient practice could affect visitors and staff who may not be aware an exit exists in the Employee lounge on Service hall.</p> <p>Findings include:</p> <p>Based on observation on 04/15/14 at 1:27 p.m. with the Maintenance Supervisor, there was no exit sign posted at the east end of the Employee lounge showing the exit discharge to the public way. Based on interview on 04/15/14 at 1:30 p.m. it was acknowledged by the Maintenance Supervisor, the exit door to a public way from the Employee lounge was not obvious without an exit a sign posted.</p>	K010047	<p>contain a double lock to the outside.</p> <p>5. Date of Correction 4-16-2014</p> <p>It is the intent of this facility to ensure that all exit areas will obtain an exit sign.</p> <p>1. On 4-17-2014, an exit sign was placed on the outside door, inside the employee break room.</p> <p>2. No residents were affected by this, as this was an employee only area, secured by a code on the door.</p> <p>3. Any doors leading to the outside will have an exit sign so that the public can find the exit.</p> <p>4. All doors will be monitored to ensure exit signs are posted</p> <p>5. Date of Correction: 4-17-2014</p>	04/17/2014
K010056 SS=E	<p>3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is</p>			

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	<p>installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observations and interview, the facility failed to ensure a complete automatic sprinkler system was provided for 1 of 2 exits with outside canopies in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13, 1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under exterior combustible roofs or canopies exceeding four feet in width. This deficient practice could affect 28 residents on 100 and 400 halls as well as staff and visitors adjacent to the front entrance.</p> <p>Findings include:</p> <p>Based on observation on 04/15/14 at 12:20 p.m. with the Maintenance Supervisor, the front entrance canopy constructed of a cloth material which connects to the building and extends fifteen feet from the front entrance lacked sprinkler protection. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the lack of sprinkler protection by the front</p>	K010056	<p>It is the intent of this facility to ensure that all canopies on the outside of the building are fire rated, or properly extinguished.</p> <ol style="list-style-type: none"> On 5/5/2014 the canopy on the front exit of the building was sprayed with fire retardant. All residents have the potential for being affected by this practice. Fire Retardant has been sprayed to ensure proper resistance to fire. Maintenance Supervisor will ensure that any canopy on the outside of the building is up to date with all fire retardants. Date of Correction: 5/5/2014 	05/05/2014

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K010130 SS=F	<p>entrance for the canopy and was unable to provide documentation of a flame spread rating for the cloth canopy.</p> <p>3.1-19(b) NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure the location of 1 of 1 liquefied petroleum gas (LPG) containers was at least 25 feet away from a designated smoking area. LSC 19.1.1.3 states health facilities shall be maintained and operated to minimize the possibility of a fire emergency. LSC 8.4.3.1(3) requires the storage and handling of flammable liquids or gases to be in accordance with NFPA 58, 1998 Edition Liquefied Petroleum Gas Code. NFPA 58, Section 3-2.2.2 requires containers installed outside of buildings to be in accordance with Table 3-2.2.2. and Section 3-2.2.2(d) requires the distance measured in any direction from the point of discharge of a container pressure relief valve, the vent of a fixed maximum liquid level gauge on a container, or the installed location of the filling connection of a container to any exterior source of ignition, openings into direct-vent (sealed combustion system) appliances, or mechanical ventilation air intakes shall be in accordance with Table 3-2.2.2(d). Table 3-2.2.2(d) indicates the minimum distance between a LPG container with a water capacity of 501-2000 gallons and an exterior ignition source is 25 feet. This deficient practice could affect any residents located next to the smoking area as well as staff or visitors using the smoking area located behind the facility near the generator.</p>	K010130	<p>It is the intent of this facility to ensure that all smoking areas are at an appropriate and safe area away from hazardous materials.</p> <ol style="list-style-type: none"> According to the 2567, it states that the LPG container is a capacity of 750 gallons. The LPG container actually holds 150 gallons. A sign was placed 4-21-14 on the LPG container stating that there should be no smoking within 25 feet of the tank. All residents have the potential to be affected by this practice. Staff was educated 4-29-14 on designated smoking areas. Maintenance supervisor will monitor to ensure signage is posted appropriately. Date of Correction: 4-29-14 	04/29/2014

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K010144 SS=F	<p>Findings include:</p> <p>Based on observation on 04/15/14 at 2:25 p.m. with the Maintenance Supervisor, the LPG container with a capacity of seven hundred and fifty gallons was fifteen feet from the designated smoking area. In addition, there were four extinguished cigarette butts within fifteen feet of the LPG container. Based on interview on 04/15/14 at 2:30 p.m., the Maintenance Supervisor acknowledged the location of the smoking area and the cigarette butts found around the LPG container was unacceptable.</p> <p>3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator annunciator panels would indicate alarm conditions. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate: 1. When the emergency or auxiliary power source is operating to supply power to load. 2. When the battery charger is malfunctioning.</p>	K010144	<p>It is the intent of this facility to ensure all generators are in working order.</p> <ol style="list-style-type: none"> On 4/18/2014, the generator annunciator panel at the north nurses station was replaced. Residents on the 300 and 400 halls could have been affected by this deficient practice. Annunciator panel will be monitored along with monthly generator inspections. Maintenance supervisor will 	04/18/2014			

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K010147 SS=E	<p>(b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate:</p> <ol style="list-style-type: none"> 1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature. 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply. 5. Overcrank (failed to start). 6. Overspeed. <p>Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect all the residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 04/15/14 at 12:55 p.m. with the Maintenance Supervisor, the test button on the alarm annunciator for the generator located in the north hall Nurse's station did not illuminate the LED function lights corresponding to the various functions for the generator. During an interview on 04/15/14 at 12:56 p.m. with the Maintenance Supervisor, it was acknowledged the function lights did not illuminate and it was further acknowledged the facility was in the process of getting a new one.</p> <p>3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p>		<p>monitor monthly generator testing and annunciator panel.</p> <p>5. Date of Correction 4-18-2014</p>	

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	<p>Based on observation and interview, the facility failed to ensure 1 of 1 extension cords was not used as a substitute for fixed wiring. NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 8 residents observed on service hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 04/15/14 at 2:11 p.m. with the Maintenance Supervisor, an extension cord was used in the north hall Nurses' station and it was connected from one six prong surge protector to power another six prong surge protector which provided electrical power to computers. Based on interview on 04/15/14 at 2:12 p.m. it was acknowledged by the Maintenance Supervisor, an extension cord was used to provide power to the aforementioned appliance and it was mentioned extension cords were not allowed in the facility.</p> <p>3.1-19(b)</p>			K010147	<p>It is the intent of this facility to ensure extension cords are not used as a substitute for fixed wiring.</p> <ol style="list-style-type: none"> On 4/17/2014, a second outlet receptacle was placed at the south nurses' station. Hope Springs was inspected and no other resident areas are affected by this deficient practice. Maintenance will supervise to ensure that no extension cords are used in place of fixed wiring. Maintenance will supervise to ensure that no extension cords are used in place of fixed wiring Date of correction: 4/17/2014 		04/17/2014