

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155242	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/10/2015
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MUNCIE	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 N WALNUT ST MUNCIE, IN 47303
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
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K 0000 Bldg. 01	<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: 12/10/15</p> <p>Facility Number: 000146 Provider Number: 155242 AIM Number: 100291200</p> <p>At this Life Safety Code survey, Signature Healthcare 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, spaces open to the corridors and battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 185 and had a census of</p>	K 0000	<p>This Plan of Correction is the facility's credible allegation of compliance. The facility respectfully requests a desk review and has provided evidence of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p>	
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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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K 0070 SS=E Bldg. 01	<p>131 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 one garage and one shed which is used to store maintenance equipment and was not sprinklered.</p> <p>Quality Review completed on 12/14/15 by Lex Brashear, LSC Specialist</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation, interview and record review; the facility failed to regulate the use of 1 of 1 portable space heaters observed in the facility. This deficient practice could affect 9 residents on 500 hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 12/10/15 at 1:30 p.m. with the Maintenance Supervisor, inside the riser room on center hall adjacent to 500 hall was a portable space heater plugged in and used to provide additional heat to the room. Based on interview on 12/10/15 concurrent with</p>	K 0070	<p>K070</p> <p>1. Corrective action accomplished for those residents found to have been affected by the deficient practice: The portable space heater was immediately removed from the facility.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: An audit of the facility was completed and no other portable space heaters were found to be in use.</p> <p>3. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur:</p>	12/22/2015

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K 0147 SS=E Bldg. 01	<p>the observation, it was acknowledged by the Maintenance Supervisor space heaters were not allowed in the facility, however, a portable space heater policy was not available to verify this.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 10 surge protectors observed including extension cords, non-fused extension cords and/or multiplug adapters were 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</p>	K 0147	<p>Staff has been educated regarding the prohibition of portable space heaters.</p> <p>4.How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: The Maintenance director will audit the facility for the use of portable space heaters weekly for 8 weeks and then monthly for two months and then quarterly for two quarters. The results of the audits will be presented to the Quality Assessment and Process Improvement Committee monthly for 3 months, then quarterly for 2 quarters and as needed thereafter.</p> <p>5.Systematic changes will be completed by December 22nd</p> <p>K147 1. Corrective action accomplished for those residents found to have been affected by the deficient practice: The personal refrigerator and microwave were immediately unplugged from the surge protector and plugged directly into a fixed wiring outlet. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be</p>	12/22/2015

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	<p>practice could affect 25 residents on 300 hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 12/10/15 at 2:30 p.m. with the Maintenance Supervisor a surge protector was used to provide power to a mini refrigerator and microwave located in the Business office by the front entrance adjacent to 300 hall. Based on interview on 12/10/15 concurrent with the observation it was acknowledged by the Maintenance Supervisor, a surge protector was used to power the aforementioned electrical appliances.</p> <p>3.1-19(b)</p>		<p>taken: An audit of the facility was completed and no surge protectors or extension cords were found to be used inappropriately. 3. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur: Staff has been educated regarding the use of surge protectors and extension cords. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: The Maintenance director will audit the facility for the use of extension cords and surge protectors weekly for 8 weeks and then monthly for two months and then quarterly for two quarters. The results of the audits will be presented to the Quality Assessment and Process Improvement Committee monthly for 3 months, then quarterly for 2 quarters and as needed thereafter. 5. Systematic changes will be completed by December 22nd</p>		