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 02/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF MUNCIE THE	2400 CHATEAU DR MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
K0000				
	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). Survey Date: 02/03/12 Facility Number: 000310 Provider Number: 155443 AIM Number: 100288970 Surveyor: Phillip Komsiski, Life Safety Code Specialist 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. 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 spaces open to the corridors. The resident rooms have battery powered smoke detection. The facility has a	K0000	Preparation and/or execution of this Plan of Correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility fo the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction and specific corrective actions are prepared and/or executed in compliance with State and Federal law. This Plan of Correction constitutes our credible allegation of compliance with regulatory requirements. Our date of compliance is March 4, 2012.	

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 determined that other safegaurds 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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	capacity of 72 and had a census of 70 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/10/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1			
	Based on observation and interview, the facility failed to ensure 3 of 6 doors leading to hazardous areas such as oxygen storage rooms, mechanical rooms and laundry rooms were provided with self closing and latching devices which would cause the door to automatically close and latch into the door frame. This deficient practice affects 24 residents on 300 hall and 5 residents on main hall and 4 residents observed in the dining room adjacent to service hall as well as visitors and staff. Findings include: Based on observation on 02/03/12 during the tour between 1:27 p.m. and 2:00 p.m. with the Maintenance Supervisor, the door to the oxygen storage room where oxygen transfer occurs on 300 hall and the door to the mechanical room on main hall adjacent to the activities room were not provided with a door closer.	K0029	It is the intent of this facility to ensure all doors leading to hazardous areas are provided with self closures and latch into its frame to meet set standards. 1. Actions taken for the residents identified: A. The doors to the oxygen room, mechanical room on main hall and laundry room on service hall all self close and latch into its frame to meet set standards. 2. How other residents were identified: A. 100% audit of the rest of the facility's hazardous rooms were inspected to meet set standards 3. Systems in place: A. The Maintenance Supervisor/designee will conduct monthly inspections of all hazardous rooms as a part of our monthly preventive maintenance program to meet set standards. 4. How monitored: A. Results of monthly inspections will be reviewed by QA Committee during quarterly QA Meetings.	03/04/2012

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	Furthermore, the door to the laundry room on service hall adjacent to the dining room was not provided with a door latching device. Based on interview on 02/03/12 concurrent with the observations with the Maintenance Supervisor, it was acknowledged the aforementioned doors leading into the oxygen storage room where oxygen transfer occurs, mechanical room and laundry room were not equipped with a door closing device or a latch device to keep the doors closed. 3.1-19(b)			

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K0048 SS=B	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1			
	Based on record review and interview, the facility failed to include the use of kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility in the event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice affects any resident, as well as staff and visitors in the vicinity of the kitchen. Findings include: Based on a review of the facility's written fire disaster plan on 02/03/12 at 3:45 p.m. with the Maintenance Supervisor the fire disaster plan did not include the use of the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on an interview on 02/03/12 at	K0048	It is the intent of this facility to ensure that it has included the use of the kitchen fire extinguishers in its written Fire Safety Plan for the facility in the event of an emergency. 1. Actions taken for the residents and staff identified: A. The Fire Safety Plan has been updated to meet set standards and all kitchen staff have been in-serviced on proper procedure to follow. 2. How other residents were identified: A. The facility only has one kitchen.3. Systems in place: A. The Maintenance Supervisor/designee will in-service all kitchen staff by 3/4/12. All new kitchen staff will be in-serviced on Facility Safety Plan during facility orientation, to meet set standard.4. Monitoring: A. In-service records will be reviewed by QA Committee during quarterly QA Committee Meetings.	03/04/2012

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	4:47 p.m. with the Maintenance Supervisor, it was acknowledged the written fire safety plan for the facility did not include mention of the K class fire extinguisher. 3.1-19(b			

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K0051 SS=F	A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6			
	Based on observation and interview, the facility failed to install 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. This deficient practice could affect all residents as well as visitors and staff. Findings include: Based on observation on 02/03/12 at 3:10 p.m. with the Maintenance Supervisor, the fire alarm system circuit breaker was	K0051	It is the intent of this facility to ensure the Fire Alarm System is in accordance with NFPA 72.1. Action taken: A. The Fire Alarm System circut breaker has a breaker lock in place and is the breaker is identified on the breaker panel.2. How other residents were identified: A. The facility only has one fire alarm system circuit breaker.3. System in place: A. The Maintenance Supervisor/designee will inspect the Fire Alarm System circuit breaker monthly as a part of the Preventive Maintenance Program.4. How monitored: A. Inspection results will be reviewed by the QA Committee during quarterly QA Committee Meetings.	03/04/2012

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	not identified in red as the FIRE ALARM CIRCUIT CONTROL. Based on interview on 02/03/12 at 3:15 p.m. with the Maintenance Supervisor, it was acknowledged the electrical breaker for the fire alarm control panel (FACP) did not have any identification to distinguish it as the power source for the FACP. 3.1-19(b)			

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K0067 SS=F	Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2			
	Based on observation and interview, the facility failed to ensure 52 of 52 resident rooms were not using the corridor as a portion of a return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilation Systems at 2-3.11.1 requires egress corridors shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. This deficient practice could affect all residents rooms in the facility as well as visitors and staff if the modifications had not been made. Findings include: Based on observations on 02/03/12 during a tour of the facility between 11:00 a.m. and 3:14 p.m. with the Maintenance Supervisor, all resident rooms were using the egress corridors as a supply air system. Based on interview on 02/03/12 concurrent with the observations with the Maintenance Supervisor, it was confirmed the return air ducts for all the resident rooms were in the corridors, however, the HVAC system was modified so actuation	K0067	It is the intent of this facility to maintain HVAC according to NFPA standards.Actions Taken:The facility reveiwed the matter, there is no threat to residents health or safety. Due to the fact the facility is a fully sprinkled building, fully operational fire alarm system with smoke detection throughout the facility, smoke duct detection installed on the air handlers affected which will activate the fire alarm system and shut down the air handlers upon activation, and has staff members and central alarm company monitoring the system 24 hours per day. To replace the effected air handlers and its duct work would be a financial hardship for the facility due to the building is completely finished out living areas.Others Identified:This is the only area of the building that has a HVAC building designed utilizing corridor as a portion of the cold are return.Measures taken:Waiver t be requested, letter attached.How Monitored:Administrator to monitor approval of waiver.As identified, the issues/concerns will be reviewed by the QA Committee during quarterly QA Committee Meetings.	03/04/2012

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	of the fire alarm system would shut down air supply fans in ventilation ducts. Additionally, smoke detectors were installed in the ventilation ductwork which shut off air supply once the fire alarm system is activated. Finally, the HVAC ducts did not penetrate any fire or smoke barrier walls, eliminating the need for the installation of smoke dampers to prevent the transfer of smoke from one smoke compartment to another. 3.1-19(b)			

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K0074 SS=E	Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3			
	Based on observation, record review and interview; the facility failed to provide flame resistant window curtains in 2 of 52 resident rooms. This deficient practice could affect 24 residents on 200 hall as well as visitors and staff. Findings include: Based on observations on 02/03/12 from 2:10 p.m. to 2:20 p.m. with the Maintenance Supervisor, the window curtains installed in resident rooms 201 and 204 lacked attached documentation confirming they were inherently flame resistant. Based on record review and interview on 02/03/12 at 3:45 p.m. with the Maintenance Supervisor, it was acknowledged there was no	K0074	It is the intent fo this facility to ensure to have flame resistant documentation in house.1. Action taken: A. Maintenance Supervisor has repaired the two resident room window curtains to meet set standard.2. How other residents were identified: A. Maintenace Supervisor will complete 100% audit of all other resident rooms to meet set standards.3. Systems in place: A. The Maintenace Supervisor/designee will audit/review the Flame Spread Documentation monthly as a part of their Preventive Maintenance Program to meet set standards.4. How monitored:Results of the audits will be reviewed by QA Committee during quarterly QA Committee Meetings.	03/04/2012

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	documentation regarding flame resistance available for review regarding the window curtains which were provided by the facility. 3.1-19(b)			