

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 02/21/2013
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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: 02/21/13</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 spaces open to the corridors. The resident rooms have battery powered smoke detection. The facility has a</p>	K010000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review or Post Survey Review on or after 03/08/2013.</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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	<p>capacity of 72 and had a census of 42 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 garage used for facility storage and a smoking shed.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/27/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010029 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 doors leading to hazardous areas on 100 hall such as rooms with combustibile items was provided with self closing devices which would cause the door to automatically close and latch into the door frame. This deficient practice could affect any staff or visitors who have access to 100 hall south where vacant resident rooms are used for storage and staff offices.</p> <p>Findings include:</p> <p>Based on observation on 02/21/13 at 1:55 p.m. with the Maintenance Supervisor, resident room number 106 on 100 hall south is used for storage of 39 large cardboard boxes, the room was greater than fifty square feet in size and it did not have a self closing device on the corridor</p>	K010029	<p>K 029 NFPA 101 Life Safety</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <ul style="list-style-type: none"> The items were removed from the area identified during survey and placed in proper storage area. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <ul style="list-style-type: none"> All residents, staff or visitors have the potential to be affected by this alleged deficient practice. 	03/08/2013			

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	<p>door. Based on interview on 02/21/13 at 1:58 p.m. with the Maintenance Supervisor, it was acknowledged the aforementioned door leading into room number 106 contained combustible items and was not equipped with a self closing device on the door.</p> <p>3.1-19(b)</p>		<p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> • During storage of combustible items, the area will be reviewed to ensure proper storage. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <ul style="list-style-type: none"> • The Maintenance Director or designee will observe and assist in the storage of materials in the facility. • A maintenance rounds quality assurance audit tool will be utilized weekly x 4, monthly x 2 and quarterly thereafter. • The Quality Assurance Committee will review the data. If threshold is not achieved, an action plan will be developed. • One on One re-education and or disciplinary action may occur for noncompliance. 		

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K010067 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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</p> <p>Based on 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 air conditioning, heating and ventilating (HVAC) duct work 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.</p> <p>Findings include:</p> <p>Based on telephone interview on 03/14/13 at 2:30 p.m. with the Plant Operation Manager, all resident rooms and the support rooms throughout the facility were using the egress corridors as a return air system.</p> <p>3.1-19(b)</p>	K010067	<p>It is the intent of this facility to maintain HVAC according to the NFPA standards. Actions Taken: The facility reviewed the matter and determined there is no threat to the health or safety of the residents, staff or visitors. This was determined based on the facility being fully functional sprinkler system and maintaining a fully operational fire alarm system with smoke detection throughout the facility (including resident rooms). Smoke detection was installed on the air handlers affected; which when activated will activate the fire alarms system and shut down the air handlers. The facility is staffed 24/7 and has the central alarm company monitoring as well. To replace the affected air handlers and its duct work would be a financial hardship for the facility due to the building is completely finished out with 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 air return. Measures taken: A waiver is being requested. Please see attached letter and documentation. How</p>	03/08/2013	

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			Monitored: Administrator to monitor for approval of the waiver. As identified, the issues/concerns will be reviewed by the QA committee during quarterly QA meetings as deemed necessary.		