STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155066	A. BUILDING -- B. WING	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EDGEWATER WOODS	1809 N MADISON AVE ANDERSON, IN 46011

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/11/25 Facility Number: 000026 Provider Number: 155066 AIM Number: 100274820 At this Emergency Preparedness survey, Edgewater Woods was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 81 and had a census of 74 at the time of this survey. Quality Review completed on 03/13/25	E 0000	This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/11/25 Facility Number: 000026 Provider Number: 155066 AIM Number: 100274820 At this Life Safety Code survey, Edgewater Woods was found not in compliance with Requirements for Participation in	K 0000	This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Victoria Kinley	Executive Director	03/27/2025

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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	Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 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, areas open to the corridors and has battery operated smoke detectors in the resident rooms. The facility has a capacity of 81 and had a census of 74 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 03/13/25			
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Based on observation and interview, the facility failed to ensure 1 of 25 portable fire extinguishers had pressure gauge readings in the acceptable range in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.2 requires periodic inspection of fire extinguishers shall include pressure gauge reading or indicator in the operable range or position. When an inspection of any rechargeable dry chemical fire extinguisher reveals a deficiency in Section 7.2.2(3) or 7.2.2(4), the extinguisher shall be subjected to applicable maintenance procedures. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of resident sleeping Room 106.	K 0355	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Vendor, Whitlock, called and charged fire extinguisher on 3/13/2025. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken** This deficient practice could affect over 20 residents, staff and visitors in the vicinity of resident sleeping	03/13/2025

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	Findings include: Based on observations with the Maintenance Director and the Director of Nursing (DON) during a tour of the facility from 12:30 p.m. to 2:00 p.m. on 03/11/25, the pressure gauge on the ABC type portable fire extinguisher in the wall mounted open cabinet in the corridor outside resident sleeping Room 106 showed the extinguisher was undercharged. The portable fire extinguisher inspection contractor had an affixed maintenance tag indicating the annual maintenance for the fire extinguisher was performed in January 2025. The affixed maintenance tag also indicated monthly inspections by facility staff had been documented through March 2025. Based on interview at the time of the observations, the Maintenance Director agreed the pressure gauge on the portable fire extinguisher in the corridor outside resident sleeping Room 106 indicated the fire extinguisher was undercharged. These findings were reviewed with the Maintenance Director and the DON during the exit conference. 3.1-19(b)		in room 106. Maintenance Director inspected all fire extinguishers on 3/12/2025 and no other issues were identified. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Maintenance Supervisor/designee to utilize CQI Tool titled "2025 Life Safety Corrective Action Monitoring" to audit fire extinguishers in facility weekly x 4 weeks, and monthly thereafter. **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;** Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held bi-monthly, and is overseen by the Executive Director. CQI tool titled "2025 Life Safety Corrective Action Monitoring" will be completed weekly x 4 weeks and monthly thereafter. If Threshold of 100% is not met, an action plan will be developed to ensure compliance.	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Based on observation and interview, the facility failed to ensure 1 of 1 therapy rooms were	K 0361	**What corrective action(s) will be accomplished for those**	05/22/2025

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	separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception per 19.3.6.1(7). LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the Therapy Room. Findings include: Based on observations with the Maintenance Director and the Director of Nursing (DON) during a tour of the facility from 12:30 p.m. to 2:00 p.m. on 03/11/25, the corridor door to the Therapy Room was not equipped with a positive latching mechanism to latch the door into the door frame. The door was equipped with a locking device which required a key to lock or unlock the door from both the corridor side of the door and the room side of the door. The door would not latch into the door frame unless it was locked. Based on interview at the time of the observations, the Maintenance Director agreed the corridor door to the Therapy Room was not equipped with a positive latching device to secure the door into the door frame and to ensure the treatment room was not open to the corridor. These findings were reviewed with the Maintenance Director and the DON during the exit conference.		**residents found to have been affected by the deficient practice;** Vendor to install positive latching hardware to Therapy Room door by 5/22/25. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken** This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the Therapy Room. All doors requiring a latching mechanism were audited on 3/12/25 by Maintenance Supervisor and no other issues were identified. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Maintenance Supervisor/designee to utilize CQI Tool titled “2025 Life Safety Corrective Action Monitoring” to audit doors in facility monthly ongoing until compliance is achieved. **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;** Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held bi-monthly,	

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	3.1-19(b)		and is overseen by the Executive Director. CQI tool titled “2025 Life Safety Corrective Action Monitoring” will be completed monthly until compliance is achieved. If Threshold of 100% is not met, an action plan will be developed to ensure compliance.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with	K 0920	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** PCREE was removed from power strip on 3/11/2025. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken** This deficient practice could affect over 20 residents, staff and visitors in the vicinity of resident sleeping in room 107. All staff were educated on correct usage of power strips and extension cords. Maintenance Director completed an audit of all resident rooms on 3/20/25 to ensure PCREE is being used properly. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;**	03/20/2025

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	grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of resident sleeping Room 107. Findings include: Based on observations with the Maintenance Director and the Director of Nursing (DON) during a tour of the facility from 12:30 p.m. to 2:00 p.m. on 03/11/25, a resident bed, an oxygen concentrator, a fan and a cell phone charging cable were plugged a power strip placed on the resident bed nearest the window in resident seeping Room 107. The UL listing of the power strip was 1363A. Based on interview at the time of the observations, the Maintenance Director agreed a power strip was being used for PCREE and non-PCREE in the patient care vicinity and as a substitute for fixed wiring in resident sleeping Room 107. These findings were reviewed with the Maintenance Director and the DON during the exit conference. 3.1-19(b)		Maintenance Supervisor/designee to utilize CQI Tool titled "2025 Life Safety Corrective Action Monitoring" to audit power strips in rooms in facility monthly ongoing. **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;** Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held bi-monthly, and is overseen by the Executive Director. CQI tool titled "2025 Life Safety Corrective Action Monitoring" will be completed monthly until compliance is achieved. If Threshold of 100% is not met, an action plan will be developed to ensure compliance.	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on record review and interview, the facility failed to conduct the required maintenance and maintain complete documentation of inspections for all Patient Care Related Electrical Equipment (PCREE). NFPA 99, Health Care Facilities Code, 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE	K 0921	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** PCREE testing to occur by May 22, 2025 by Maintenance Director/designee.	05/22/2025

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	is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice affects all residents in the facility. Findings include: Based on record review with the Maintenance Director and the Director of Nursing (DON) from 9:40 a.m. to 12:30 p.m. on 03/11/25, PCREE testing documentation was not available for review. Based on interview at the time of record review, the Maintenance Director stated Corporate staff has hired a contractor to perform all PCREE testing for the facility but the contractor testing has yet to be performed and agreed PCREE testing documentation was not available for review. These findings were reviewed with the Maintenance Director and the DON during the exit conference.		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken** This deficient practice has the potential to affect all residents in the facility. Maintenance Supervisor/designee to ensure that electrical testing occurs on all PCREE in resident rooms in accordance with Life Safety codes. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Maintenance Supervisor educated on PCREE testing requirements. PCREE testing and verification to be added to preventative maintenance log to ensure ongoing compliance. **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;** Executive Director/Designee will review PCREE testing and maintenance logs. If Threshold of 100% is not achieved, an action plan will be developed to ensure compliance.	

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	3.1-19(b)			