STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155038	A. BUILDING -- B. WING	01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS EDGE VILLAGE	2200 WEST WHITE RIVER BLVD MUNCIE, IN 47303

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/24/24 Facility Number: 000013 Provider Number: 155038 AIM Number: 100266100 At this Emergency Preparedness survey, Waters Edge Village 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 74 and had a census of 58 at the time of this survey. Quality Review completed on 01/26/24	E 0000	I am seeking a Desk/paper review IDR for K 211 please. I would also like to request a paper compliance review. Thank you.	
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: 01/24/24 Facility Number: 000013 Provider Number: 155038 AIM Number: 100266100 At this Life Safety Code survey, Waters Edge Village was found not in compliance with Requirements for Participation in	K 0000	I am seeking a Desk/paper review IDR for K 211 please. I would also like to request a paper compliance review. Thank you.	

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 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(OOO) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident sleeping rooms. The facility has a capacity of 74 and had a census of 58 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 01/26/24			
K 0222 SS=F Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.			

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	18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted			

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	on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 8 of 8 exit doors in the facility were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect all the residents except those in the Dementia Care Unit. Findings include: Based on observation with the Executive Director (ED) and Maintenance Director (MD) on 01/24/24 at 12:50 p.m., the exit door at the Main Entrance was marked as a facility exit, was magnetically locked, and could be opened by entering a four-digit code on the keypad, the code was posted at the exit but was covered with a blank receptacle cover that could be moved to the side to see the door code. The other exit doors in the facility had the same condition. Based on interview at the time of observation, the Maintenance Director stated the code to open the exit doors was posted but covered with the blank receptacle cover. This requires special knowledge to open the exit doors. This finding was reviewed with the Executive Director and Maintenance Director during the exit	K 0222	-Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents have been affected. The Maintenance director has relabeled the receptacle plate from "look under" to read "look under for code" 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; All residents have the potential to be affected. The Maintenance director has relabeled the receptacle plate from "look under" to read "look under for code" for all facility exit doors. what measures will be put into place or what systemic	02/15/2024

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	conference. 3.1-19(b)		changes will be made to ensure that the deficient practice does not recur; The Maintenance Director will check the receptacle plates at least weekly during the weekly door safety check and or with each change of the exit code. Any issue will be corrected immediately. 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; The Maintenance Director will report any issues during each scheduled QAPI meeting.	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are			

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	used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 46 resident rooms flexible cords were not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, 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. This deficient practice affects staff and up to 2 residents in room 107. Findings include: Based on observation with the Executive Director (ED) and Maintenance Director (MD) on 01/24/24 at 01:20 p.m. there was a resident personal electrical powered item plugged into a lamp outlet in resident room 107. Based on interview at the time of each observation, the ED and MD acknowledged the aforementioned condition and removed the lamp. This finding was reviewed with the ED and MD at the exit conference 3.1-19(b)	K 0920	Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No other residents were found to have a lamp with a plug in on it, or any type of extension cords. 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; Each room was checked by a member of the Management team and no other lamps with a plug in on it or extension cords were in use. Staff were inserviced on lamps that are non-compliant with life safety code and on the	02/15/2024

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			use of non-approved power strips and extension cords. what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Residents bringing in lamps from home will be examined by the Maintenance director or a member of the management staff to ensure there are no violations present. 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; The maintenance director will complete monthly checks to ensure no unauthorized lamps or extension cords are in use.	