

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155038		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 02/26/2024	
NAME OF PROVIDER OR SUPPLIER WATERS EDGE VILLAGE				STREET ADDRESS, CITY, STATE, ZIP COD 2200 WEST WHITE RIVER BLVD MUNCIE, IN 47303			
(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
K 0000 Bldg. 01	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 01/24/24 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a).</p> <p>Survey Date: 02/26/24</p> <p>Facility Number: 000013 Provider Number: 155038 AIM Number: 100266100</p> <p>At this Life Safety Code PSR Survey Waters Edge Village was found not in compliance with the Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.90(a) 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.</p> <p>This one story facility was determined to be Type V(000) 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.</p> <p>The facility has 74 certified beds. At the time of survey the census was 60.</p> <p>Quality Review completed on 03/01/24</p>			K 0000	I would like to request paper compliance for F222		
K 0222 SS=F Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

James Thomas

Executive Director

03/13/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosable 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>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. 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</p>						

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	<p>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 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.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director (MD) on 02/26/24 at 02:00 p.m., the exit door at the Main Entrance was marked as a facility</p>			K 0222	<p>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.</p> <p>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 Code" to read "look</p>		02/27/2024

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	<p>exit, was magnetically locked, and could be opened by entering a four-digit code on the keypad, the code was posted at the exit near the keypad but was covered with a blank receptacle cover that could be moved to the side to see the door code. There was a label on the cover stating, "Look under code". The remaining exit doors in the facility with the exception of the north exit door near the smoking area were set up the same way. At the north exit, the code covered by the blank receptacle cover was 5 feet away from the keypad. Based on interview at the time of observation, the Maintenance Director stated he would move the code and cover next to the North exit door keypad and agreed the label stating "look under code" was not clear and still would require special knowledge to open the exit doors.</p> <p>This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.</p> <p>This deficiency was cited on 01/24/24. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p>				<p>under for code" on all exit doors. The north exit receptacle cover has been relocated to within 12 inches of the code box at a height easily seen by wheelchair bound residents and visitors.</p> <p>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 Code" to read "look under for code" for all facility exit doors.</p> <p>what measures will be put into place or what systemic 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.</p> <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; The Maintenance Director will report any issues during each scheduled QAPI meeting.</p>		

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