

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

PRINTED: 03/16/2023
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 02/20/23</p> <p>Facility Number: 000086 Provider Number: 155170 AIM Number:</p> <p>At this Emergency Preparedness survey, Westminster Village Muncie Inc 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 76 and had a census of 62 at the time of this survey.</p> <p>Quality Review completed on 02/22/23</p>			E 0000	<p>The submission of this Plan of Correction (HCFA-2567) does not constitute an admission by Westminster Village Muncie, Inc. of any fact or conclusion set forth in the Statement of Deficiencies. This Plan of Correction is being submitted because it is required by law.</p> <p>Furthermore, we request that this Plan of Correction serve as our credible allegation of compliance. We respectfully request paper compliance.</p> <p>Compliance is effective <u>March 20, 2023</u></p> <p><u>Mary Jo</u> <u>Crutcher, HFA</u> President/Administrator</p> <p><u>March</u> <u>3, 2023</u></p> <p>Date</p>		
K 0000							

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

TITLE

(X6) DATE

Mary Jo Crutcher

HFA, President

03/03/2023

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 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 30 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.

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

PRINTED: 03/16/2023
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155170		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC				STREET ADDRESS, CITY, STATE, ZIP COD 5801 W BETHEL AVE MUNCIE, IN 47304			
(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
Bldg. 01	<p>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).</p> <p>Survey Date: 02/20/2023</p> <p>Facility Number: 000086 Provider Number: 155170 AIM Number:</p> <p>At this Life Safety Code survey, Westminster Village Muncie Inc. was found not in compliance with Requirements for Participation in 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.</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, areas open to the corridors and in the resident rooms. The facility has a capacity of 76 and had a census of 62 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review completed on 02/22/23</p>			K 0000	<p>The submission of this Plan of Correction (HCFA-2567) does not constitute an admission by Westminster Village Muncie, Inc. of any fact or conclusion set forth in the Statement of Deficiencies. This Plan of Correction is being submitted because it is required by law.</p> <p>Furthermore, we request that this Plan of Correction serve as our credible allegation of compliance. We respectfully request paper compliance.</p> <p>Compliance is effective <u>March 20, 2023</u></p> <p><u>Mary Jo</u> <u>Crutcher, HFA</u> President/Administrator</p> <p><u>March</u> <u>3, 2023</u></p> <p>Date</p>		
K 0211 SS=E Bldg. 01	<p>NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit</p>						

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

PRINTED: 03/16/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155170		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC				STREET ADDRESS, CITY, STATE, ZIP COD 5801 W BETHEL AVE MUNCIE, IN 47304			
(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
	<p>discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.</p> <p>18.2.1, 19.2.1, 7.1.10.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 corridor means of egresses were continuously maintained free of obstructions. LSC 19.2.3.4 (4) states projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met:</p> <p>(a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm).</p> <p>(b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency.</p> <p>(c)The wheeled equipment is limited to the following:</p> <p>i. Equipment in use and carts in use</p> <p>ii. Medical emergency equipment not in use</p> <p>iii. Patient lift and transport equipment</p> <p>This deficient practice affects residents in the area of resident rooms 53 and 55.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Physical Plant Director (PPD) on 02/20/23 at 12:15 p.m., in the vicinity of resident room 53 and 55, two Personal Protective Equipment (PPE) carts were in use but were not equipped with wheels allowing the carts to be moved out of the halls during an emergency. Based on an interview at the time of observations, the PPD stated that he was not aware that wheels</p>			K 0211	<p>ID PREFIX TAG K211 SS=E</p> <p>1.) Personal Protective Equipment (PPE) carts were removed from use.</p> <p>2.) The carts are being replaced with over the door isolation containers that will hold necessary PPE.</p> <p>3.) This will prevent obstruction from any egress with isolation containers now being placed on the doors of residents requiring isolation. See included pictures.</p> <p>4.) Skilled Care maintenance employee/designee will complete hallway checks routinely as part of weekly audits. Any concerns will be carried to the monthly Quality Assurance Committee meeting for the next nine months.</p> <p>5.) Date of compliance: 3/20/23</p>		03/20/2023

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

PRINTED: 03/16/2023
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155170	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 02/20/2023
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC			STREET ADDRESS, CITY, STATE, ZIP COD 5801 W BETHEL AVE MUNCIE, IN 47304		
(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 0363 SS=D Bldg. 01	<p>are required on the PPE carts in the corridor.</p> <p>The finding was reviewed with the President and the PPD during the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101</p> <p>Corridor - Doors</p> <p>Corridor - Doors</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.</p> <p>Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are</p>				

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

PRINTED: 03/16/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155170		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC				STREET ADDRESS, CITY, STATE, ZIP COD 5801 W BETHEL AVE MUNCIE, IN 47304			
(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 0500 SS=E Bldg. 01	<p>allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of 1 resident room corridor doors was provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 1 resident in room 56.</p> <p>Findings include:</p> <p>Based on observation with the Physical Plant Director (PPD) on 02/20/23 at 12:15 p.m., the corridor door to resident room 56 did not latch into the frame when tested. Based on interview at the time of observation, the Maintenance Director stated the corridor door would not latch into the door frame but he will fix it.</p> <p>The finding was reviewed with the President and the PPD during the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This</p>			K 0363	<p>ID PREFIX TAG K363 SS=D</p> <p>1.) During the observation walkthrough in excess of 80 doors were checked for impediment to closing and latching. One door for room 56 noted to have impediment and was corrected within an hour of the finding.</p> <p>2.) All other doors checked immediately for proper latching and no impediment to closing.</p> <p>3.) Housekeeping weekly check list updated on 2/27/23 to included checking the door latches. See attached list.</p> <p>4.) Housekeeping staff in-service on the additional weekly check of doors properly latching. Any concerns will be taken to Quality Assurance Committee meeting for the next nine months.</p> <p>5.) Date of Compliance 2/27/23.</p>		02/27/2023

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

PRINTED: 03/16/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155170		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC				STREET ADDRESS, CITY, STATE, ZIP COD 5801 W BETHEL AVE MUNCIE, IN 47304			
(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 0920 SS=F Bldg. 01	<p>information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure 2 of 2 fuel fired water heaters and 2 of 2 boilers had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect staff and residents in the area of the main boiler room .</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Physical Plant Director (PPD) on 02/20/23 at 12:05 p.m. the two boilers and the hot water heater in the main boiler room had inspection certificates with an expiration date of 01/17/22. Based on interview at the time of the observation, the PPD stated the inspections for these items have been difficult to get and agreed the hot water heater inspection was past due and needed to be inspected.</p> <p>This finding was reviewed with the President and PPD at the exit conference.</p> <p>3.1-19(b)</p> <p>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</p>			K 0500	<p>ID PREFIX TAG K500 SS=E</p> <p>1.) To address the facilities failure to ensure proper inspection certificates for fuel fired water heaters and boilers the Property & Casualty Insurance Representative was contacted 2/21/23. It was determined that during a transition between insurance carriers during COVID-19 shut down, our facilities name had been incorrectly removed from the inspection list.</p> <p>2.) Westminster's Property and Casualty Company had an inspector on site the afternoon of 2/21/23 to complete all inspections. All passed without error.</p> <p>3.) Certifications of proper inspections will be received by mail.</p> <p>4.) Physical Plant Director will review certifications as needed to insure compliance remains in place. Any concerns will be carried to the Quality Assurance Committee for the next nine months.</p> <p>5.) Date of Compliance: 3/20/23.</p>		03/20/2023

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

PRINTED: 03/16/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155170		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>patient-care-related electrical equipment (PCREE) assemblies 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 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 20 of 20 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Physical Plant Director (PPD) on 02/20/23 at 11:35 a.m., the 20 display cabinets located in the corridor alcoves between each resident room were powered by extension cords. Based on interview at the time of observation, the PPD acknowledged the extension cords were in use, but said they have always been that way.</p>			K 0920	<p>ID PREFIX TAG K920 SS=F</p> <p>1.) During the observations walkthrough it was noted that the 20 locked display cabinets that hold patient medicine were powered by an extension cord for the internal lights as installed by the manufacturer.</p> <p>2.) Physical Plant Director/Designee planning to replace the extension cords with 110 direct wiring to a switch inside the cabinet which was then plugged directly into the outlet.</p> <p>3.) Consultation with a third party licensed electrician was done to insure the correction would meet electrical code. See attached pictures showing before</p>		03/06/2023

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

PRINTED: 03/16/2023
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155170	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 02/20/2023
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC			STREET ADDRESS, CITY, STATE, ZIP COD 5801 W BETHEL AVE MUNCIE, IN 47304		
(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 0923 SS=E Bldg. 01	<p>The finding was reviewed with the President and the PPD during the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage</p>		<p>and after.</p> <p>4.) Physical Plant Director/Designee has a policy in place to prevent use of extension cord. Routine audits will be performed and reported to Quality Assurance Committee for the next nine months.</p> <p>5.) Date of compliance 3/6/2023.</p>		

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

PRINTED: 03/16/2023
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155170		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 02/20/2023	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC				STREET ADDRESS, CITY, STATE, ZIP COD 5801 W BETHEL AVE MUNCIE, IN 47304			
(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
	<p>room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."</p> <p>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.</p> <p>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)</p> <p>Based on observation and interview, the facility failed to ensure empty cylinders are segregated from full cylinders and are marked to avoid confusion. This deficient practice could affect up to 15 residents in one smoke compartment.</p> <p>Findings include:</p> <p>Based on observations with the Physical Plant Director (PPD) on 02/20/23 at 11:55 a.m. in the oxygen storage room there was means to separate full cylinders from empty cylinders but there were empty cylinders intermingled with full cylinders. Based on interview at the time of observation, the PPD stated that the empty cylinder section was full and so staff put empty cylinders in the full cylinder section.</p> <p>The finding was reviewed with the President and PPD during the exit conference.</p> <p>3.1-19(b)</p>			K 0923	<p>ID PREFIX TAG K923 SS=E</p> <p>1.) Immediate correction of empty oxygen tanks being moved to the appropriate distance away from full tanks.</p> <p>2.) All empty tanks were returned to appropriate oxygen vendor. Signage was already in place for storage of both empty and full tanks.</p> <p>3.) Nurse Software Specialist/Designee will be inspecting the oxygen storage room daily to assure proper storage of oxygen tanks. In-servicing will take place on 3/7/23 with all nursing staff.</p> <p>4.) Audits of inspection will be reviewed in monthly Quality Assurance meeting for the next nine months. Any concerns noted will be addressed and corrected immediately by ADON/Designee.</p> <p>5.) Date of compliance: 3/2/23.</p>		03/02/2023