STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155242	A. BUILDING -- B. WING	10/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIGNATURE HEALTHCARE OF MUNCIE	4301 N WALNUT ST 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: 10/18/21 Facility Number: 000146 Provider Number: 155242 AIM Number: 100291200 At this Emergency Preparedness survey, Signature Healthcare of Muncie was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 140 certified beds. At the time of the survey, the census was 110. Quality Review completed on 11/01/21	E 0000		
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: 10/18/21 Facility Number: 000146 Provider Number: 155242 AIM Number: 100291200 At this Life Safety Code survey, Signature	K 0000		

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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	Healthcare of Muncie was not found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The building was surveyed with Chapter 19 Existing Health Care Occupancies. This one story facility was determined to be of Type V (000) construction and was fully sprinkled. The facility has a fire alarm system with smoke detection in corridors, areas open to the corridor, and battery operated smoke detectors in the resident rooms. The facility has a capacity of 140 and had a census of 110 at the time of this survey. All areas where the residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 11/01/21			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____			

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	Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to maintain 1 of 1 automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observation on 10/18/21 at 11:28 a.m. with the Maintenance Supervisor (MS), the most recent sprinkler report from Koorsen dated 05/10/21 in the comments section stated: "West riser ITV clogged recommend a flush on west riser". Based on interview at the time of observation the MS stated the flush on the west riser had not been done. This was discussed with the Administrator during the exit conference. 3.1-19(b)	K 0353	1.What corrective action will be accomplished for the residents found to have been affected by the deficient practice West riser flush was performed on 10/20/2021 at 830 am any and all repairs performed 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken All residents have the potential to be affected. West riser flush was performed on 10/20/2021 at 830 am and all repairs performed 3. What measures will be put in place and what systematic changes will be made to ensure that the deficient practice does not reoccur. The maintenance director or designee will monitor all inspection reports for any repairs needed and follow up on any recommendations on a weekly basis ongoing. 4. How the corrective action will be monitored to ensure the deficient practice does not recur i.e. what quality assurance program will be put into place The maintenance director will report the results of all inspections	11/12/2021

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			and the action taken to the QAPI committee monthly ongoing.	
K 0354 SS=F Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a written policy containing procedures to be followed for the protection of 110 of 110 residents in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.5 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 10/18/21 at 11:59 a.m. with the Maintenance Supervisor (MS), the	K 0354	1.What corrective action will be accomplished for the residents found to have been affected by the deficient practice The fire watch policy has been changed to include ISDH, owner operator or monitoring company 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken All residents have the potential to be affected. The fire watch policy has been changed to include ISDH, owner operator or	11/12/2021

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	facility provided Fire Watch Policy and Procedure documentation but it was incomplete. The Fire Watch Policy and Procedure plan only contacts staff, local fire authorities and insurance carrier once the Sprinkler system has been placed out of service and a call back to same once the sprinkler system has been restored. The policy did not include contacting ISDH, owner operator or monitoring company. This was confirmed and reviewed with the Administrator during the exit conference. 3.1-19(b)		monitoring company 3. What measures will be put in place and what systematic changes will be made to ensure that the deficient practice does not reoccur. Staff has been in serviced on the revision of the fire watch policy 4. How the corrective action will be monitored to ensure the deficient practice does not recur i.e. what quality assurance program will be put into place Maintenance director or designee will report on any occurrence of Fire Watch to the QAPI quarterly ongoing	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure 1 of 7 smoke barriers observed had a minimum of a 1/2 hour fire resistive rating	K 0372	1.What corrective action will be accomplished for the residents found to have been affected by the	11/12/2021

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	and the penetrations caused by the passage of wire and/or conduit the smoke barrier walls was protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect 15 residents, visitors and staff. Findings include: Based on observation on 10/18/21 at 2:55 p.m. with the Maintenance Supervisor (MS), there was a sprinkler pipe to the left of the 300 smokewall which had a one inch opening around the pipe which was left unsealed. Based on interview after physical observation by the MS it was confirmed the 300 smokewall had a penetration through the smokewall with an opening that was not firestopped to maintain a 1/2 hour fire resistive rating. This finding was reviewed with the Administrator and MS during the exit conference 3.1-19(b)		deficient practice Fire wall was sealed with fire stop on 10/22/2021 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken All residents have the potential to be affected. Fire wall was sealed with fire stop on 10/22/2021 3. What measures will be put in place and what systematic changes will be made to ensure that the deficient practice does not reoccur. The maintenance director or designee will monitor inspect for penetrations monthly ongoing 4. How the corrective action will be monitored to ensure the deficient practice does not recur i.e. what quality assurance program will be put into place The maintenance director or designee will monitor inspect for penetrations and report to the QAPI committee monthly for four months and then quarterly until the QAPI committee establishes that continued compliance has been achieved	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment			

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	complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 2 of 2 electrical receptacles observed was protected accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect mostly staff. Findings include: Based on observations on 10/18/21 during the tour between 2:00 p.m. to 2:42 p.m. with the Maintenance Supervisor (MS), the GFCI outlet outside 900 hall was not protected with a cover plate. Also, there was an outlet to the right of the sink in the Beauty shop on 200 which was not protected with a cover plate. Based on interview at the time of observations, the MS confirmed the receptacle cover plates were not present. This was discussed with the Administrator and MS during the exit conference. 3.1-19(b)	K 0511	1.What corrective action will be accomplished for the residents found to have been affected by the deficient practice The cover plates have been correctly installed 10/24/2021 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken All residents have the potential to be affected. The cover plates have been correctly installed 10 3. What measures will be put in place and what systematic changes will be made to ensure that the deficient practice does not reoccur. The maintenance director or designee will perform inspection of receptacles for any repairs needed monthly. 4. How the corrective action will be monitored to ensure the deficient practice does not recur i.e. what quality assurance program will be put into place The maintenance director will report the results of all inspections and the action taken to the QAPI committee monthly ongoing.	11/12/2021
K 0712 SS=F	NFPA 101 Fire Drills			

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Bldg. 01	Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to ensure fire drills were held on all shifts for 2 of 4 quarters over the past year. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of Monthly Fire Drill Reports on 10/18/21 at 12:20 p.m., with the Maintenance Supervisor (MS) there were no fire alarm drill reports available for review for the following shifts: a. Second and third shifts of the second quarter of 2021. b. First, second and third shifts of the fourth quarter of 2020. Based on an interview with the MS at the time of record review, it was confirmed items a and b had not been done. This was reviewed with the Administrator during the exit conference. 3.1-19(b)	K 0712	1.What corrective action will be accomplished for the residents found to have been affected by the deficient practice 1st fire drill was performed 10/24/2021 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken 1st fire drill was performed 10/24/2021 and will perform all three shifts monthly starting November for three months 3. What measures will be put in place and what systematic changes will be made to ensure that the deficient practice does not reoccur. The maintenance director or designee will perform fire drills	11/12/2021

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			quarterly on each shift 4. How the corrective action will be monitored to ensure the deficient practice does not recur i.e. what quality assurance program will be put into place The maintenance director or designee will perform fire drills quarterly on each shift ongoing and report the results of those drills quarterly to the QAPI committee ongoing.	
K 0920 SS=E 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 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			

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	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 proper use of power strips in 1 of 1 areas observed. This deficient practice could affect up to 2 staff including residents and visitors. Findings include: Based on observations on 10/18/21 at 2:23 p.m. with the Maintenance Supervisor (MS), a power strip was used to power a coffee maker in the Admissions office on 400 hall. Based on interview concurrent with the observation with the MS, it was acknowledged the power strip was improperly used. This finding was discussed with the Administrator and MS during the exit conference. 3.1-19(b)	K 0920	1.What corrective action will be accomplished for the residents found to have been affected by the deficient practice Coffee maker has been removed from service. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken All residents have the potential to be affected. Coffee maker has been removed from service. Staff has been in-serviced on use of power strips. 3. What measures will be put in place and what systematic changes will be made to ensure that the deficient practice does not reoccur. The maintenance director or designee will monitor all offices for use of power strips monthly. 4. How the corrective action will be monitored to ensure the deficient practice does not recur i.e. what quality assurance program will be put into place The maintenance director will report the results of all inspections and the action taken to the QAPI committee monthly for 2 months and then quarterly for two quarters until compliance has been achieved for 2 consecutive	11/12/2021

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			quarters.	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen transfilling rooms was mechanically ventilated. NFPA 99 2012 edition, 11.5.2.3.1 (2) requires oxygen transfilling rooms to be mechanically ventilated, is sprinklered, and have ceramic or concrete flooring. This deficient practice could affect 22 residents, visitors or staff. Findings include: Based on observation on 10/18/21 at 3:45 p.m. with the Maintenance Supervisor (MS), the Oxygen storage room on 800 hall, where oxygen transfilling occurred had a ceiling exhaust fan which appeared not to work. Based on an interview at the time of observation, the MS was asked to test the exhaust vent with a piece of paper to observe movement which would indicate the ceiling vent was working. After the test it was verified the vent was not working. This finding	K 0927	1.What corrective action will be accomplished for the residents found to have been affected by the deficient practice 800 hall exhaust fan was repaired on 10/29/2021 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken All residents have the potential to be affected. 800 hall exhaust fan was repaired on 10/29/2021 3. What measures will be put in place and what systematic changes will be made to ensure that the deficient practice does not reoccur. The maintenance director or designee will inspect the fan for	11/12/2021

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	was reviewed with the Administrator MS at the exit conference. 3.1-19(b)		operation monthly ongoing. 4. How the corrective action will be monitored to ensure the deficient practice does not recur i.e. what quality assurance program will be put into place The maintenance director will report the results of all inspections and the action taken to the QAPI committee monthly for two months and then quarterly for 2 months until compliance has been achieved for two consecutive quarters.	