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	04/18/2024

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: 04/18/24 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 75 at the time of this survey. Quality Review completed on 04/24/24	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 on or after May 10, 2024.	
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: 04/18/24 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 on or after May 10, 2024.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Doug Lynch	HFA	05/09/2024

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 battery operated smoke detectors in the resident rooms. The facility has a capacity of 81 and had a census of 75 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 04/24/24			
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 penetrations through 2 of 8 smoke	K 0372	What corrective actions will be accomplished for those residents	04/19/2024

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	barrier walls smoke barriers were 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. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 50 residents in three smoke compartments. Findings include: Based on observation with the Maintenance Director on 04/18/24 at 12:20 p.m., in the attic, the smoke barrier wall by room 118 and the fire/smoke barrier wall by the 100-hall nurses station, there were two 2" inch pipe sleeves containing wires without the ends sealed. Based on an interview at the time of observation, the Maintenance Director agreed the two pipe sleeves were not sealed. This finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		found to have been affected by the deficient practice: The open pipes described have been appropriately sealed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents have the potential to be affected. All other smoke barriers have been checked for compliance. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: All smoke barriers have been checked for compliance. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Visual checks will be performed daily x 2 weeks, biweekly x 2, and monthly x 3.	

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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 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 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. 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 up to 5 residents outside of the business office. Findings include:	K 0920	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The power strip was removed and all other offices were checked for the same deficiency. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:	04/19/2024

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	Based on observations with the Maintenance Director on 04/18/24 at 11:05 a.m., a refrigerator and a microwave (high power draw equipment) were plugged into and supplied power by a power strip in the business office. Based on interview at the time of observation, the Maintenance Director acknowledged a power strip was supplying power to high power draw equipment. This finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		All residents have the potential to be affected by the alleged deficient practice. All office holders have been educated on this practice. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance Director or designee will do a sweep monthly to ensure that power strips are not present.. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Results from Maintenance will be discussed monthly x 3 to the QAPI committee.	
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 trans-filling rooms were separated from other areas in the facility in a	K 0927	What corrective actions will be accomplished for those residents found to have been affected by the	04/26/2024

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	room that is protected with a one-hour fire-resistive construction in accordance with 2012 NFPA 99 11.5.2.3.1(1). This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Director on 04/18/24 at 11:45 a.m., the oxygen trans-filling room was not protected with a one-hour fire-resistive construction due to the door did not have fire rating label or other documentation to show the fire rating of the door. Based on an interview at the time of observation, the Maintenance Director agreed the fire rating on the door could not be determined. This finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		deficient practice: The proper fire rated door was installed 4/26/24. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: 20 residents have the potential to be affected by this practice. The door was replaced 4/26/24. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Hazard Vulnerability Assessment is performed annually. ED/ Maintenance will ensure that all policies are in place for any potential hazards and observed for compliance. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Prior to the annual Hazard Vulnerability Assessment, Maintenance/designee will observe fire rated doors for compliance.	