PRINTED: 06/19/2024 FORM APPROVED OMB NO. 0938-039

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

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155443		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 05/29/2024		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD HATEAU DR		
WATERS OF MUNCIE, THE					E, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		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: 05/29/24  Facility Number: 000310 Provider Number: 155443 AIM Number: 100288970  At this Emergency Preparedness survey, The Waters 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 a capacity of 72 and had a census of 50 at the time of this survey.  Quality Review completed on 05/31/24		E 00	Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 06/03/2024.  Facility respectfully requests a desk review.		eral, not  he set ection s are deral ation ory	
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: 05/29/24  Facility Number: 000310 Provider Number: 155443 AIM Number: 100288970  At this Life Safety Code survey, The Waters of Muncie was found not in compliance with Requirements for Participation in		K 0	000	Preparation and/or execution this plan of correction in general or this corrective action does constitute an admission agreement by this facility of the facts alleged or conclusions of forth in this statement of deficiencies. The plan of corrective action prepared and/or executed in compliance with state and feel laws. This plan of correction constitutes our credible allegator of compliance with all regulaters.	eral, not he set ection s are deral	

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

TITLE

(X6) DATE

Brenda Darlien Alfrey Executive Director 06/19/2024

Any defiency statement 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 disclodays 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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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155443		UILDING	onstruction  01	(X3) DATE COMPL <b>05/29</b> /	ETED	
NAME OF PROVIDER OR SUPPLIER WATERS OF MUNCIE, THE			2400 CI	ADDRESS, CITY, STATE, ZIP COD HATEAU DR E, IN 47303		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Life Safety from Fin National Fire Protec Life Safety Code (L	te and the 2012 edition of the etion Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2.		requirements. Our date of compliance is 06/03/2024. Facility respectfully requests a desk review.	a	
	Type V111 construction The facility has a find detection in the corricorridors and batter the resident sleeping	ity was determined to be of ction and was fully sprinklered. The alarm system with smoke ctidors, areas open to the cy powered smoke detection in cy rooms. The facility has a census of 50 at the time				
	All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.  Quality Review completed on 05/31/24					
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting of than required encl exits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containin combustible mater hardware. Roller la CMS regulation. T apply to auxiliary s flammable or com	corridor openings in other osures of vertical openings, is areas resist the passage made of 1 3/4 inch wood or other material g fire for at least 20 fully sprinklered smoke only required to resist the c. Corridor doors and doors ag flammable or rials have positive latching atches are prohibited by these requirements do not spaces that do not contain				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 05/29/2024 155443 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2400 CHATEAU DR WATERS OF MUNCIE, THE MUNCIE, IN 47303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 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 K 0363 K363 - It is the intent of the 06/03/2024 failed to ensure 1 of around 50 sets of resident facility to provide resident room room doors to the corridor would close completely doors to the corridor that will close and latch into the door frame. This deficient completely and latch into the door practice could affect as many as 2 residents, 2 frame to meet set standards. staff and 2 visitors in the facility. **CORRECTIVE ACTIONS** TAKEN: Findings include: On 5/29/2024 the Maintenance Supervisor/designee Based on observations made during a tour of the

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facility on 05/29/24 at 1:12 p.m. with the facility

present, resident room # 304 failed to latch into

the door frame. Based on interview at the time of

acknowledged the resident room door as not fully

Administrator and the Maintenance Director

observations, the Maintenance Director

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made repairs to resident room

into the door frame to meet set

standards. The Administrator

#304 door to ensure door latches

verified the repairs on 5/29/2024.

POTENTIAL TO BE AFFECTED:

**ALL OTHERS WITH** 

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155443		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 05/29/2024	
	PROVIDER OR SUPPLIER		2400 0	ADDRESS, CITY, STATE, ZIP COD CHATEAU DR CIE, IN 47303	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
TAG	REGULATORY OR closing and latching that he would look a This item was agair conference with the	into the doorframe adding at it as soon as possible.  I discussed at the exit facility Administrator and the or on 05/29/24 at 1:55 p.m.	TAG	a All residents and all sta and visitors have the potential be affected but none were. It maintenance Supervisor/desinspected all doors and found other negative findings.  3 MEASURES TO PREVINGE (See a On 5/29/2024 the Administrator in serviced the Maintenance Supervisor/and other staff members on the requirement to provide reside room doors that would close completely and latch fully into frame to meet set standards. b Maintenance Supervisor/designee will inspall doors throughout the facility monthly to ensure resident rodoors will close completely a latch fully into the frame as a of the facility's Preventive Maintenance Program and document those inspection reas appropriate. If any issued discovered, they will be addreand resolved immediately. The Maintenance Supervisor/designee will review with the Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.  4 MONITORING CORRECTIVE ACTION:	ff al to The gnee d no ENT  all ent o the ect ty com nd part esults s are essed he gnee ator

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155443	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	COMP	E SURVEY LETED 0/2024
	ROVIDER OR SUPPLIER		2400 C	ADDRESS, CITY, STATE, ZIP C CHATEAU DR IE, IN 47303	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
K 0914 SS=E Bldg. 01	NFPA 101 Electrical Systems Testing Electrical Systems Testing Hospital-grade rec	s - Maintenance and s - Maintenance and ceptacles at patient bed		be presented by the M Supervisor/designee to Administrator monthly Administrator will prese inspection results at th Quality Assurance/Per Improvement (QA/PI) Inspection results and components will be revithe QA/PI Committee to subsequent plans of codeveloped and implement deemed necessary to compliance is maintain. This plan of correction constitutes our creditallegation of compliantall regulatory requires Our date of compliance desk review.	o the and the ent the e monthly formance meeting. system viewed by with brrection mented as ensure med. n ble nce with ments. ce is	
	anesthesia is adminitial installation, in Additional testing defined by docume Receptacles not lithese locations are exceeding 12 mor (LIM), if installed, if	re deep sedation or general inistered, are tested after replacement or servicing. is performed at intervals ented performance data. sted as hospital-grade at the tested at intervals not withs. Line isolation monitors are tested at intervals of				
	•	to 1 month by actuating per 6.3.2.6.3.6, which				

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	R MEDICARE & MEDIC					MB NO. 0938-039
	AND PLAN OF CORRECTION  NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE		(X2) MULT A. BUILD B. WING	TIPLE CONSTRUCTION DING 01	COM	e survey pleted 9/2024
			STREET ADDRESS, CITY, STATE, ZIP COD 2400 CHATEAU DR MUNCIE, IN 47303			•
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PRI	D PROVIDER'S PLAN OF C  EFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE AG DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	LIM circuits with a manual test is per than or equal to 1 tested per 6.3.3.3 renovation to the Records are main associated repairs containing date, results. 6.3.4 (NFPA 99) Based on record resinterview, the facility nonhospital-grade cresident room locate annually. NFPA 99 2012 Edition, Section to listed as hospital locations and in locations a	view, observation, and ty failed to ensure all electrical receptacles at ions were tested at least, Health Care Facilities Code on 6.3.4.1.3 states receptacles al-grade, at patient bed ations where deep sedation or is administered, shall be tested eeding 12 months. on 6.3.2.2, Receptacle Testing oms requires the physical ceptacle shall be confirmed by the continuity of the in each electrical receptacle shall t polarity of the hot and neutral in electrical receptacle shall be ention force of the grounding rical receptacle (except acles) shall be not less than ess). This deficient practice y as 25 residents, 4 staff, and 2	K 0914	K914– It is the intent to ensure all non-hos electrical receptacles room locations are to annually to meet set 1 CORRECTIVE TAKEN:  a On 6/3/2024 th Maintenance Superv conducted the annual receptacle inspection documented the rest facilities Life safety best standards. The verified repairs on 6/2 ALL OTHERS POTENTAL TO BE A a All residents are and visitors have the beaffected but none 3 MEASURES TOREOCCURRENCE:  a On 6/3/2024 the Administrator in serve Maintenance Supervented to electrical receptacle	spital grade s at resident ested at least standards. ACTIONS  ne visor/designee al electrical n and ults in the binder to meet Administrator vis/2024. WITH AFFECTED: nd all staff e potential to e were. O PREVENT  ne viced the visor/designee he annual	06/03/2024

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Maintenance Director at 11:00 a.m., when asked to

review the annual receptacle retention

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and testing must be completed

annually and documented in the

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155443	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER WATERS OF MUNCIE, THE			2400 0	ADDRESS, CITY, STATE, ZIP CO CHATEAU DR EIE, IN 47303	D
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION (X5)  ULLD BE COMPLETION PROPRIATE DATE
TAG	documentation, the that he had not comstating that he was completed receptace conducted on 04/03 months old. During a.m. to 1:45 p.m., thad roughly four to each room. Based cobservation, the Mall of the electrical rooms were not host there was no up to testing per NFPA 9 requirements for return of the conference with the	Maintenance Director stated appleted all the resident rooms only half finished. The last le retention test was 3/23 and was more that twelve a tour of the facility from 11:02 he facility's 50 resident rooms as ix electrical receptacles in on interview at the time of the maintenance Director indicated receptacles in the resident spital-grade and also indicated date documentation of annual 19, Receptacle Testing	TAG	life safety binder to mee standards.  b Maintenance Supervisor/designee wil the annual electrical recinspection and testing is completed and document part of the facility's Previous Maintenance Program a document those inspect as appropriate. If any is discovered, they will be and resolved immediate Maintenance Supervisor will review with the Admithe inspection results.  c The Administrator monitor adherence to the Preventative Maintenance Supervisor will review and validate the Preventative Maintenance Supervisor monitor adherence to the Preventative Maintenance Supervisor monitor adherence to the Preventative Maintenance Supervisor monitor adherence to the Preventative Maintenance Supervisor Maintenance M	I ensure eptacle inted as a rentive and ion results ssues are addressed ely. The r/designee inistrator  will e ce ne ce ine ce i

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CENTERSTON	WIEDICHNE & WEDIC	IID SERVICES			On	D 110. 0700 007	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	01	COMPLETED			
		155443	B. WING		05/29/2024		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2400 CHATEAU DR MUNCIE, IN 47303				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
				constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 6/3/2024.  Facility respectfully requests desk review.			

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