PRINTED: 08/24/2023 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC				OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDEN		IDENTIFICATION NUMBER	A. BUILDING	<u></u>	COMPLETED		
		155443	B. WING 07/27/2023				
	PROVIDER OR SUPPLIER		2400 (CADDRESS, CITY, STATE, ZIP COD CHATEAU DR CIE, IN 47303			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)		
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION		
TAG	· ·	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE		
E 0000							
Dida							
Bldg		paredness Survey was diana Department of Health in CFR 483.73.	E 0000				
	Survey Date: 07/27	1/23					
	Facility Number: 00 Provider Number: 1 AIM Number: 100	55443					
	Waters of Muncie v Emergency Prepare Medicare and Medi and Suppliers, 42 C capacity of 72 and I of this survey.	Preparedness survey, The was found in compliance with dness Requirements for caid Participating Providers FR 483.73. The facility has a had a census of 54 at the time					
	Quality Review con	npleted on 08/02/23					
K 0000							
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 07/27 Facility Number: 0 Provider Number: 1 AIM Number: 1002 At this Life Safety 0	00310 55443	K 0000	The following Plan of Correct constitutes the facility's writter allegation of compliance for the deficiency cited. However, submission of this Plan of Correction is not an admission and does not constitute an agreement with alleged deficiencies herein. The Plan Correction is submitted to me the requirements established the state and federal regulation.	en he on to of eet by		
	Requirements for Pa			TDISCLAIMER STATEMENT	·,		
	1 1 1 101 1		1	, . DIOUEZIMEN UIZIENEN	•		

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

(X6) DATE

TITLE

Brenda Alfrey **Executive Director** 08/22/2023

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.

Event ID: Facility ID: 000310 If continuation sheet

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 155443	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/27/2023			
	PROVIDER OR SUPPLIER S OF MUNCIE, THE	2400 C	STREET ADDRESS, CITY, STATE, ZIP COD 2400 CHATEAU DR 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 APPROPRIA DEFICIENCY)	DATE			
	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 V111 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 powered smoke detection in the resident sleeping rooms. The facility has a capacity of 72 and had a census of 54 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 08/02/23		Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of facts alleged or conclusions forth in this statement of deficiencies. The plan of correction and specific corrective actions are preparand/or executed in complian with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance wifederal Medicare and Medicaid requirements. Facility request a desk review on K211, K918, K920. The facility requests a desk review.	the set			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit 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. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 2 of 2 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	K 0211	K211 – It is the intent of the facility to ensure corridor mean egress are continuously maintained free of all obstruction meet set standards. CORRECTIVE ACTION	ons			

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Event ID:

 $O4W621 \hspace{0.5cm} \textit{Facility ID:} \hspace{0.5cm} 000310$

If continuation sheet

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB	OMB NO. 0938-039	
STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SU	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	G <u>01</u>	COMPLET	TED	
		155443	B. WING		07/27/20	023	
NAME OF PROVIDER OR SUPPLIER WATERS OF MUNCIE, THE		240 MU	EET ADDRESS, CITY, STATE, ZIP COI 00 CHATEAU DR INCIE, IN 47303	1			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREY (EACH CORRECTIVE ACTION SHOWN)		(X5)	
TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFI TAG	CROSS-REFERENCED TO THE APP	PROPRIATE	COMPLETION DATE	
	following condition			TAKEN:			
		uipment does not reduce the		a. On 07/28/23 the	/		
		corridor width to less than 60		Maintenance Supervisor			
	in.(1525 mm).	C C 1 1		removed the PPE carts t			
		occupancy fire safety plan and		observed by rooms 303,			
		ldress the relocation of the		and 413 to meet set star			
		during a fire or similar		The Administrator verifie	d the work		
	emergency.	ipment is limited to the		on 07/28/23 . 2. ALL OTHERS WI T	ru		
	following:	inplinent is infinited to the					
	i. Equipment in use	and corts in usa		a. All residents and a			
		and carts in use			and visitors have the potential to		
	iii. Patient lift and to				be affected but none were. On		
		ice affect 15 residents in the			07/28/23 the Maintenance		
	facility.	ice affect 13 residents in the		Supervisor/designee ins			
	lacinty.			corridors and exit doors	·		
	Findings include:			no other negative finding			
	i manigs merade.			3. MEASURES TO P	·		
	Based on an observ	ation during a tour of the		REOCCURRENCE:	KLVLINI		
		intenance Supervisor 07/27/27		a. On 07/28/23 the			
	_	and 02:05 p.m., in two resident		Administrator in-serviced	1 the		
	_	onal Protective Equipment		Maintenance Supervisor			
		use but were not equipped		and all other staff on 08.	- 1		
	, ,	ng the carts to be moved out of		requirement that the corr			
		emergency. The PPE carts were		means of egress are to r			
	_	303,310, 409, and 413. Based		free of obstructions and			
	-	he time of observations, the		must have wheels allowi			
		visor stated the PPE carts were		carts to be moved out of	-		
	not equipped with v	wheels and would need to have		during an emergency to	meet set		
	wheels added.			standards.			
				b. Maintenance			
	These findings were	e reviewed with the		Supervisor/designee will	inspect		
	Administrator and t	he Maintenance Supervisor		all corridor means of egr			
	during the exit conf	erence.		throughout the facility we	eekly for		
				obstructions and will ens	sure PPE		
	3.1-19(b)			carts have wheels allowi	ng them		
				to be moved out of the h	alls during		
				an emergency as a part	of the		
				facility's monthly Preven	tive		

Maintenance Program and

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

PRINTED: 08/24/2023 FORM APPROVED OMB NO. 0938-039

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155443	B. WING 07/27/2023				
				_			
NAME OF I	PROVIDER OR SUPPLIER	<u>.</u>			ADDRESS, CITY, STATE, ZIP COD		
10/07-5	OF MUNICIPE TO :-				HATEAU DR		
WATERS	S OF MUNCIE, THE			MUNCI	E, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					document those inspection res	sults	
					as appropriate. If any issues		
					discovered, they will be addre		
					and resolved immediately. Th		
					Maintenance Supervisor/desig		
					will review with the Administra		
					the inspection results.		
					c. The Administrator will		
					monitor adherence to the		
					Preventative Maintenance		
					schedule and validate the		
					Preventative Maintenance		
					documentation is in place.		
					4. MONITORING		
					CORRECTIVE ACTION:		
					a. The inspection results w	/ill	
					be presented by the Maintena	nce	
					Supervisor/designee to the		
					Administrator monthly and the		
					Administrator will present the		
					inspection results at the month	nly	
					Quality Assurance/Performand	ce	
					Improvement (QA/PI) meeting		
					Inspection results and system		
					components will be reviewed I	оу	
					the QA/PI Committee with		
					subsequent plans of correction	า	
					developed and implemented a	IS	
					deemed necessary to ensure		
					compliance is maintained.		
					This plan of correction		
					constitutes our credible		
					allegation of compliance with	n	
					all regulatory requirements.		
					Our date of compliance is		
					08.03.23.		
K 0040	NEDA 464						
K 0918	NFPA 101	Facetial Florida C. 1					
SS=F	-	s - Essential Electric Syste					
Bldg. 01	i ⊨iectrical Systems	s - Essential Electric	1				1

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Event ID:

O4W621

Facility ID: 000310

If continuation sheet

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STATEMEN	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>01</u> COMPL		ETED				
		155443	B. WI	NG		07/27/	
				_	_		
NAME OF I	PROVIDER OR SUPPLIEF	DER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD					
		_			HATEAU DR		
WATERS	WATERS OF MUNCIE, THE			MUNCI	E, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	12	DATE
	System Maintena	nce and Testing					
	The generator or	other alternate power					
	source and assoc	iated equipment is capable					
	of supplying servi	ce within 10 seconds. If the					
	10-second criterio	on is not met during the					
	monthly test, a pro	ocess shall be provided to					
	annually confirm t	his capability for the life					
	safety and critical	branches. Maintenance					
	and testing of the	generator and transfer					
	switches are perfo	ormed in accordance with					
	NFPA 110.						
	Generator sets ar	e inspected weekly,					
	exercised under lo	oad 30 minutes 12 times a					
	year in 20-40 day	intervals, and exercised					
	once every 36 mo	onths for 4 continuous hours.					
	Scheduled test un	nder load conditions include					
	a complete simula	ated cold start and					
	automatic or man	ual transfer of all EES					
	loads, and are cor	nducted by competent					
	personnel. Mainte	nance and testing of stored					
	energy power sou	rces (Type 3 EES) are in					
	accordance with N	NFPA 111. Main and feeder					
	circuit breakers ar	re inspected annually, and a					
	program for period	dically exercising the					
	components is es	tablished according to					
	manufacturer requ	uirements. Written records					
	of maintenance a	nd testing are maintained					
	and readily availa	ble. EES electrical panels					
	and circuits are m	arked, readily identifiable,					
	and separate from	n normal power circuits.					
	Minimizing the po	ssibility of damage of the					
	emergency power	source is a design					
	consideration for i	new installations.					
	6.4.4, 6.5.4, 6.6.4	(NFPA 99), NFPA 110,					
	NFPA 111, 700.10						
		view and interview, the facility	K 0	918	K918– It is the intent of the fac	cility	08/03/2023
		of 1 Emergency Power			to ensure to maintain emerger	псу	
	, , ,	accordance with NFPA 110,			power standby system in		
	_	gency and Standby Power			accordance with NFPA 110,		
	Systems, Section 8.	4.9, as required by NFPA 99			standard for emergency and		

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Event ID:

O4W621 Facility ID: 000310

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFY		IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
	155443		B. W	B. WING 07/27/2023			2023
NAME OF 1	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
					HATEAU DR		
WATERS	S OF MUNCIE, THE			MUNCI	E, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Health Care Facilit	ies Code, Section 6.4.1.1.6.1.			standby power systems, Sect	ion	
	NFPA 110 Section	8.4.9 states that all Level 1			8.4.9, as required by NFPA 99	9	
	Emergency Power	Systems shall be tested under			healthcare facilities code, sec	tion	
		very three years. Where the			6.4.1.1.6.1 to meet set standa		
	assigned class is gr	eater than 4 hours, it shall be			1. CORRECTIVE ACTION	s	
		ate the test after 4 hours.			TAKEN:		
	_	6.4.1.1.6.1 states that Type 1 and			a. On 08.01.23 the		
		ectrical system power sources			Maintenance Supervisor/Facil	ities	
		at Type 10, Class X, Level 1			Certified Contractor/designee		
		s deficient practice could			conducted the four-hour load	test	
	affect all building of	-			for the emergency generator a		
	Findings include: During records review with the Maintenance				documented the results to me		
					set standards.	Ci.	
					2. ALL OTHERS WITH		
					POTENTIAL TO BE AFFECT	ED:	
	Supervisor on 07/2						
	_	four hour load run test for the					
					and visitors have the potential	, tO	
		or conducted within the last 36			be affected but none were.		
	_	ovided for review. Based on			3. MEASURES TO PREVI	=NI	
		ne of records review, the			REOCCURRENCE:		
	_	rvisor stated a four hour			a. On 07/28/23 the		
		the emergency generator			Administrator in-serviced the		
		conducted in the past 36			Maintenance Supervisor/design	-	
	months.				on the requirement that a four	-hour	
					load test on the emergency		
		eviewed with the Administrator			generator must be conducted		
	and Maintenance S	upervisor at the exit			once every three years and		
	conference.				documented to meet set		
					standards.		
	3.1-19(b)				b. The Maintenance		
					Supervisor/designee will ensu	re an	
					annual four-hour load test on	the	
					emergency generator is cond	ucted	
					once every three years and		
					documented as a part of the		
					facility's Preventive Maintenar	псе	
					Program and document those	,	
					inspection results as appropri		
					If any issues are discovered,		
					will be addressed and resolve	-	

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

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AND PLAN OF CORRECTION 155443 NAME OF PROVIDER OR SUPPLIER WATERS OF MUNCIE, THE STREET ADDRESS, CITY, STATE, ZIP COD 2400 CHATEAU DR MUNCIE, IN 47303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD 2400 CHATEAU DR MUNCIE, IN 47303 (X5) COMPLETED 07/27/2023 (X5) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE CORRECTION FEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DATE Immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. C. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.
NAME OF PROVIDER OR SUPPLIER WATERS OF MUNCIE, THE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION (X5) COMPLETION DATE ID PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. C. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance
WATERS OF MUNCIE, THE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance
WATERS OF MUNCIE, THE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION IMPREFIX TAG IMPROVIDERS PLAN OF CORRECTION COMPLETION DATE COMPLETION DATE Immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG (EACH DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE COMPLETION DATE
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG Immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance
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monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance
Preventative Maintenance schedule and validate the Preventative Maintenance
schedule and validate the Preventative Maintenance
documentation is in place
i la
2. MONITORING
CORRECTIVE ACTION:
a. The inspection results will
be presented by the Maintenance
Supervisor/designee to the
Administrator monthly and the
Administrator will present the
inspection results at the monthly
Quality Assurance/Performance
Improvement (QA/PI) meeting.
Inspection results and system components will be reviewed by
the QA/PI Committee with
subsequent plans of correction
developed and implemented as
deemed necessary to ensure
compliance is maintained.
This plan of correction
constitutes our credible
allegation of compliance with
all regulatory requirements.
Our date of compliance is
08.03.23.
K 0020 NEDA 404
K 0920 NFPA 101 SS=E Electrical Equipment - Power Cords and
Bldg. 01 Extens Electrical Equipment - Power Cords and
Electrical Equipment - Power Cords and Extension Cords
Power strips in a patient care vicinity are only

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If continuation sheet

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA (X2) M		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155443	B. WING		07/27/	07/27/2023	
				CED DEET A	ADDRESS OF A STATE OF SOR	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD HATEAU DR		
\\/\TED	COLMUNICIE THE	-					
WAIER	ATERS OF MUNCIE, THE			MONCI	E, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	used for compone	ents of movable					
	patient-care-relate	ed electrical equipment					
	(PCREE) assemb	les that have been					
	assembled by qua	alified personnel and meet					
	the conditions of	10.2.3.6. Power strips in					
	the patient care vi	cinity may not be used for					
	non-PCREE (e.g.	, personal electronics),					
	except in long-ter	m care resident rooms that					
	do not use PCRE	E. Power strips for PCREE					
	meet UL 1363A o	r UL 60601-1. Power strips					
	for non-PCREE in	the patient care rooms					
	(outside of vicinity	r) meet UL 1363. In					
	non-patient care r	ooms, power strips meet					
	other UL standard	ls. All power strips are					
	used with general	precautions. Extension					
	cords are not use	d as a substitute for fixed					
	wiring of a structu	re. Extension cords used					
	temporarily are re	moved immediately upon					
	completion of the	purpose for which it was					
	installed and mee	ts the conditions of 10.2.4.					
	10.2.3.6 (NFPA 9	9), 10.2.4 (NFPA 99), 400-8					
		(D) (NFPA 70), TIA 12-5					
	Based on observation	on and interview, the facility	K 0	920	K920– It is the intent of the fac	cility	08/03/2023
		f 1 flexible cords were not used			to ensure flexible cords are no	t	
		ixed wiring. NFPA-70/2011,			used as a substitute for fixed		
		pecifically permitted in 400.7			wiring to meet set standards.		
		eables shall not be used for (1)			1. CORRECTIVE ACTION	S	
		ixed wiring. This deficient			TAKEN:		
	•	et any residents or staff in the			a. On 07.28.23 the		
	front office area.				Maintenance Supervisor/desig		
					removed the extension cord from		
	Findings include:				the Social Services office to m		
					set standards. The Administra		
		on and interview during a tour			verified the removal of the core	d on	
	1	the Maintenance Supervisor on			07.28.23 .		
		.m., a refridgerator was plugged			2. ALL OTHERS WITH		
		ower by an extension cord in			POTENTAL TO BE AFFECTE		
		office. Based on interview at			a. All residents and all staf		
		tion, the Maintenance			and visitors have the potential		
	Supervisor acknow	ledged an extension cord was			be affected but none were. Or	n	

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

PRINTED: 08/24/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFY		IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLET			ETED	
155443		B. WING 07/27/2023			2023		
			<u> </u>	STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	2			HATEAU DR		
WATERS	OF MUNCIE, THE	:			E, IN 47303		
VVAILING	O WIGHOL, ITIE	-		WONCI	L, II + 1 000		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY)		DATE
	in use and removed	the extension cord.			07.28.23 the Maintenance		
		the state of the state of			Supervisor/designee inspected		
		viewed with the Maintenance			rooms throughout the facility for	or	
	_	Administrator during the exit			extension cords and found no		
	conference.				other negative findings.		
	2.1.10%				3. MEASURES TO PREVE	EN I	
	3.1-19(b)				REOCCURRENCE:		
					a. On 07.28.23 the		
					Administrator in-serviced the		
					Maintenance Supervisor/desig		
					and all other staff on 08.01.23		
					requirement that extension co		
					are not to be used as a substit		
					for fixed wiring to provide pow		
					equipment with a high current		
					draw in the facility to meet set		
					standards.		
					b. Maintenance	o t	
					Supervisor/designee will inspe		
					all rooms throughout the facilit	.y	
					monthly and remove any	rt of	
					extension cords found as a pa	II L OI	
					the facility's Preventive		
					Maintenance Program and	culto	
					document those inspection res		
					as appropriate. If any issues discovered, they will be addre		
					and resolved immediately. Th		
					Maintenance Supervisor/desig		
					will review with the Administra		
					the inspection results.	i.oi	
					c. The Administrator will		
					monitor adherence to the		
					Preventative Maintenance		
					schedule and validate the		
					Preventative Maintenance		
					documentation is in place.		
					4. MONITORING		
					CORRECTIVE ACTION:		
					a. The inspection results w	/ill	
	l		1		1		i

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

PRINTED: 08/24/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155443	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE COMPL 07/27 /	LETED		
NAME OF PROVIDER OR SUPPLIER WATERS OF MUNCIE, THE			STREET ADDRESS, CITY, STATE, ZIP COD 2400 CHATEAU DR MUNCIE, IN 47303					
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R 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		
				be presented by the Maintena Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performand Improvement (QA/PI) meeting Inspection results and system components will be reviewed at the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 08.03.23.	nly ce cy n as			

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