PRINTED: 05/22/2025

CENTERS FO	OMB NO. 0938-039					
STATEME	NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155443	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/22/2025	
	PROVIDER OR SUPPLIE		2400 0	ADDRESS, CITY, STATE, ZIP COD		
WATER	S OF MUNCIE, TH	E	MUNC	IE, IN 47303		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
TAG			TAG	DEFICIENCY)	DATE	
E 0000						
Bldg			E 0000	Disclaimer Statement: Preparation and/or execution of this plan of correction in gener or this corrective action, does a constitute an admission or agreement by this facility of the facts alleged or conclusions seforth in this statement of deficiencies. The plan of correction and specific correcti actions are prepared and/or executed in compliance with stand federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medic and Medicaid requirements.	ral, not e et ive tate	
E 0006 SS=C Bldg), 416.54(a)(1)-(2), 418 II Hazards Risk Assessment				
3	failed to maintain plan (EPP) that we documented, facil risk assessment, u including missing for addressing em risk assessment in	eview and interview, the facility an emergency preparedness as based on and includes a ity-based and community-based tilizing an all-hazards approach, clients and included strategies ergency events identified by the accordance with 42 CFR 142 CFR 483.475(a) (2). This	E 0006	E006– It is the intent of the factor to ensure to maintain an emergency preparedness plant is based on and includes a documented, facility based and community-based risk assessment, utilizing an all hazards approach, including missing residents and included	that	

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

deficient practice could affect all occupants.

Findings include:

Robin Huston

TITLE

strategies for addressing

emergency events identified by the

risk assessment in accordance with 42 CFR 483.475 (a) (1) and

> (X6) DATE 05/21/2025

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: Y50Q21 Facility ID: 000310 If continuation sheet Page 1 of 24

Administrator

PRINTED: 05/22/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155443		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	COMP	E SURVEY PLETED 2/2025	
	PROVIDER OR SUPPLIER S OF MUNCIE, THE	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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	TION JLD BE ROPRIATE	(X5) COMPLETION DATE	
	Based on records review and interview with the Administrator (AD) and the Maintenance Director (MD) on 04/22/25 at 11:20 a.m., no documentation could be found regarding a documented facility-based and community-based risk assessment utilizing an all-hazards approach. This finding was acknowledged by the MD and AD at the time of observation and again at the exit conference with the MD and Administrator present.		42 CFR 483.475(a) (2) to standards. 1 Corrective Action T a On 5/05/2025 the Maintenance Supervisor, the Administrator updated emergency preparedness includes a documented, the based and community-basessment, utilizing an a hazards approach which reviewed annually to meet standards. The Administred the work 5/05/202 2 All Others With Pott Be Affected: a All residents and all and visitors have the pott be affected but none werd 3 Measures To Preverse Reoccurrence: a On 5/08/2025 and 8 the Administrator inservice Maintenance Supervisor/DON/designest aff on the requirement of the emergency preparedness must include a facility based and annually to meet set stands b The Maintenance Supervisor/DON/Administignee will ensure the emergency preparedness plan must facility based and community-based risk assessment, utilizing an a hazards approached and community-based risk assessment, utilizing an analytic transport of the memory of	raken: , DON and d the s plan and facility ased risk all is et set strator 25. ential To I staff ential to re. ent 5/10/2025 ced the re and all that the s plan sed and all I reviewed adards. strator/des ergency include a all		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y50Q21

Facility ID: 000310

If continuation sheet

Page 2 of 24

PRINTED: 05/22/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155443		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 04/22/2025			ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2400 CHATEAU DR MUNCIE, IN 47303				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
E 0037 SS=C		5.54(d)(1), 418.113(d)(IAU	annually to meet set standards c The Administrator will monitor adherence to the Emergency Preparedness Pol Manual and validate the documentation is in place. 4 Monitoring Corrective Action: a The Administrator and Maintenance Supervisor/DON/designee will review the Emergency Preparedness Policy Manual a make changes as necessary to meet set standards. Those reviews will be documented as appropriate. The Administrato present the training results at Quality Assurance/ Performan Improvement (QA/PI) meeting Results and system componer will be reviewed by the QA/PI Committee with subsequent profice for correction developed and implemented as deemed necessary to ensure compliant is maintained. This plan of correction constitution compliance with all regulatory requirements. Our date of compliance is 5/22/2025.	and o s r will the nce l. nts lans	DATE	
Bldg		view and interview, the facility nual training for the	E 0037	E037 – It is the intent of the facility to ensure to conduct		05/22/2025	

FORM CMS-2567(02-99) Previous Versions Obsolete

Emergency Preparedness Program (EPP). The LTC

Event ID:

Y50Q21

Facility ID: 000310

If continuation sheet

annual training for the Emergency

Page 3 of 24

	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155443		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMI	(X3) DATE SURVEY COMPLETED 04/22/2025	
	PROVIDER OR SUPPLIES		2400 C	ADDRESS, CITY, STATE, ZIP CO CHATEAU DR IE, IN 47303	D		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	CCTION ULD BE PROPRIATE	(X5) COMPLETION DATE	
IAG	facility must do all training in emerger procedures to all no individuals providi and volunteers, cor roles; (ii) Provide extraining at least and documentation of a training; (iv) Democemergency procedu 483.73(d) (1). This all residents in the Findings include: Based on records re Administrator (AD (MD) on 04/22/25 of annual EEP train show staff could do EPP was available interview at the tim stated the training of This finding was as AD at the time of control of the state of the	of the following: (i) Initial ney preparedness policies and ew and existing staff, ng services under arrangement, nsistent with their expected emergency preparedness nually; (iii) Maintain all emergency preparedness onstrate staff knowledge of ares in accordance with 42 CFR deficient practice could affect	IAG	Preparedness Program meet set standards. 1 Corrective Action of 5/08/2025 and 5/10/2 Administrator and Maints Supervisor/DON/designe completed an inservice of the documentation and sucknowledgment to dem knowledge of the EPP to meet set standards. 2 All Others with Pothe Affected: a All residents and a and visitors have the pothe affected but none were demonstrator inserviced Maintenance Supervisor department heads / designed the requirement to ensure demonstrate knowledge EPP trainings to meet set standards. b DON/Maintenance Supervisor All department designee will work with the Administrator to ensure demonstrate knowledge EPP trainings to meet set standards. If any issued discovered, they will be and resolved immediate c The Administrator monitor adherence to the Emergency Preparedness.	Taken: 2025 the enance ee sheet with staff nonstrate raining to tential to tential to tential to re. ent I the DON/ r/All ignee on re all staff of the et ent heads / the all staff of the et s are addressed ly. will ee	DATE	

PRINTED: 05/22/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155443		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION C	(X3) DATE SURVEY COMPLETED 04/22/2025	
	PROVIDER OR SUPPLIER		STREET 2400 (MUNC		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
				Manual and validate the documentation is in place. 4 Monitoring Corrective	
				Action: At least annually to ensure compliance, the Administrator and DON/Maintenance Supervisor/designee will review Emergency Preparedness Policy Manual and conduct required exercises and make changes an necessary to meet set standard. Those reviews will be documen as appropriate. The Administrate will present the training results at the Quality Assurance/ Performance Improvement (QA meeting. 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 constitute our credible allegation of compliance with all regulatory requirements. Our date of compliance is 5/22/2025.	the by s sls. ted for at /PI)
K 0000					
Bldg. 01	Licensure Survey w	Recertification and State vas conducted by the Indiana Ith in accordance with 42 CFR	K 0000	Disclaimer Statement: Preparation and/or execution of this plan of correction in genera or this corrective action, does n	ıl,

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y5OQ21 Facility ID: 000310

If continuation sheet Page 5 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155443	B. WING 04/22/2025			2025	
		1		STREET 4	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	R	2400 CHATEAU DR				
WATERS	OF MUNCIE, THE		MUNCIE, 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 APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	Survey Date: 04/22/25				constitute an admission or agreement by this facility of the		
	E TE AL 1	00210			facts alleged or conclusions se	et	
	Facility Number: 0				forth in this statement of		
	Provider Number: 155443 AIM Number: 100288970				deficiencies. The plan of		
	Alivi Number: 100.	288970			correction and specific correct	ive	
	At this Life Safety (Code survey, The Waters of			actions are prepared and/or executed in compliance with s	tate	
	•	not in compliance with			and federal laws. This plan of		
	Requirements for P	-			correction constitutes a writter		
		, 42 CFR Subpart 483.90(a),			allegation of substantial	-	
	Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA)101, Life Safety Code (LSC), Chapter 19, Existing				compliance with Federal Medi	care	
					and Medicaid requirements.		
	Health Care Occupa	ancies and 410 IAC 16.2.					
	This one-story facility was determined to be of type V (111) construction and was fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery powered smoke detectors in all resident sleeping rooms. The healthcare portion of the facility has a capacity of 72 and had a census of 44 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except for one garage used for storage and a shed used for smoking. Quality Review completed on 04/25/25						
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other						
Diag. 01	failed to ensure 1 of was free of lint and states all health care	on and interview, the facility f 1 laundry area dryer rooms other debris. LSC 19.1.1.3.1 e facilities shall be designed, ined and operated to minimize	K 0	100	K100– It is the intent of the factor ensure laundry area dryer rooms are free of lint and othe debris to meet set standards. 1.Corrective Actions Taken:	-	05/22/2025

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y5OQ21 Facility ID: 000310

If continuation sheet

Page 6 of 24

PRINTED: 05/22/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155443		A. BUILDING 01 B. WING		COMPLETED 04/22/2025			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD				
WATERS	OF MUNCIE, THE		2400 CHATEAU DR MUNCIE, IN 47303				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
TAG		ire emergency requiring the	TAG	a On 5/02/25 the Mainten	DATE		
		ants. This deficient practice		Supervisor cleaned the lint from			
	could affect mostly	3 laundry staff.		the area behind the dryers in			
	Findings include:			laundry area and also remove boxes and other combustible	ed the		
				material that was being stored	i		
		on and interview with the		behind the dryers to meet set	I		
		or (MD) on 04/22/25 at 1:05		standards. The Administrator			
	* '	d the dryers in the laundry		verified the work on 5/05/25.			
		ly covered with dryer lint.		2			
	-	l boxes and other combustible		All Others with Potenial to	be		
	material was being stored behind the three gas			Affected: a All residents and all staf			
	fired dryers. The MD agreed that there was combustible material behind the dryers.			a All residents and all state and visitors have the potentia			
	comoustion materia	if beining the dryers.		be affected but none were.	110		
	This finding was ac	knowledged by the MD at the		be affected but florie were.			
		and again at the exit		3 Measures to Prevent			
		MD and Administrator		Reoccurrence:			
	present.			a On 5/05/25 the			
				Administrator inserviced the			
	3.1-19(b)			Maintenance Supervisor/All			
				laundry staff/designee on the			
				requirement to ensure laundry			
				area dryer rooms are kept fre			
				lint and other debris to meet s	et		
				standards.	-/		
				b Maintenance Supervisor Laundry Supervisor/designee			
				ensure laundry area dryer roo			
				are kept free of lint and other	1110		
				debris as a part of the facility's	5		
				weekly Preventive Maintenan			
				Program and document those			
				inspection results as appropri			
				If any issues are discovered,			
				will be addressed and resolve	d		
				immediately. The Maintenand			
				Supervisor/designee will revie	w		
				with the Administrator the			
				inspection results.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y5OQ21 Facility ID: 000310

If continuation sheet

Page 7 of 24

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155443	B. WI	NG		04/22/	/2025
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	Ł	2400 CHATEAU DR				
WATERS	OF MUNCIE, THE		_	MUNCI	E, IN 47303		
(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	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					c The Administrator will		
					monitor adherence to the Preventative Maintenance		
					schedule and validate the		
					Preventative Maintenance		
					documentation is in place.		
					documentation is in place.		
					4 Monitoring Corrective		
					Action:		
					a The inspection results w	ill	
					be presented by the Maintena		
					Supervisor/designee to the		
					Administrator monthly and the		
					Administrator will present the		
					inspection results at the month	ıly	
					Quality Assurance/Performand	ce	
					Improvement (QA/PI) meeting		
					Inspection results and system		
					components will be reviewed I	эу	
					the QA/PI Committee with		
					subsequent plans of correction		
					developed and implemented a	IS	
					deemed necessary to ensure		
					compliance is maintained.		
					This plan of correction constitu	ıtes	
					our credible allegation of		
					compliance with all regulatory		
					requirements. Our date of		
					compliance is 5/22/25.		
K 0222	NFPA 101						
SS=F	Egress Doors						
Bldg. 01	Lgicas Dools						
J.49. 01	Based on observation	on and interview, the facility	K 02	222	K222– It is the intent of the fac	cility	05/22/2025
		means of egress through all	15 0.	<u></u>	to ensure the means of egress	-	0312212023
		cessible for residents without a			through exit doors are readily	•	
		equiring specialized security			accessible for residents withou	ut a	
		rithin a required means of			clinical diagnosis requiring		
		equipped with a latch or lock			specialized security measures	to	
		e of a tool or key from the			meet set standards.		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155443		A. BUILDING B. WING	01	COMPLETED 04/22/2025			
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2400 CHATEAU DR				
WATERS	OF MUNCIE, THE			IE, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
IAU	egress side unless of 19.2.2.2.4. Door-lo permitted in accordadeficient practice could the facility. Findings include: Based on observation Maintenance Direct following exit doors magnetically locked entering a four-digit posted at the exits; a) at 10:25 a.m. the b) at 12:30 p.m. exit c) at 12:35 p.m. the exit door was incorred) at 12:47 p.m. the e) at 1:06 p.m. exit of at 1:07 p.m. both room. This finding was act time of observation	cherwise permitted by LSC cking arrangements shall be ance with 19.2.2.2.5.2. This buld affect all if needing to exit on and interview with the for (MD) on 04/22/25 the arranged as facility exits, were and could be opened by code but the code was not front door in the main lobby. It door near RR# 404. Code posted at the employee	IAG	1 Corrective Actions Take a On 5/05/25 the Maintena Supervisor/designee posted the information on how to obtain to code on the following 6 exit do 1. Front door in the main lobb Exit door near RR#404 3. Employee exit door 4. Exit door near RR# 312 5. Exit door in service hall and 6. Both exit do from the dining room to meet standards. The Administrator verified the work on 5/05/25. 2 All Others with Potential be Affected: a All residents and all staff and visitors have the potential be affected but none were. O 5/05/25 the Maintenance Supervisor/designee inspecte doors and found no other neg findings. 3 Measures to Prevent Reoccurrence: a On 5/08/25 and 5/10/20 the Administrator inserviced the Maintenance Supervisor/all staff/designee to ensure code posted at exit doors to meet s standards. b Maintenance Supervisor/designee will ensu codes are posted at exit doors a part of the facility's monthly Preventive Maintenance Prog and document those inspection results as appropriate. If any issues are discovered, they we income the service of the systems of the systems of the systems in the systems of th	n: ance he he he cors y 2. or the oors set to f I to n d all ative 25 he s are et ure s as ram on		

PRINTED: 05/22/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155443		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED B. WING 04/22/2025		COMPLETED			
	ROVIDER OR SUPPLIEF		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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) addressed and resolved immediately. The Maintenance Supervisor/designee will revie 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. 4 Monitoring Corrective Action: a The inspection results w be presented by the Maintena Supervisor/designee to the Administrator monthly and the	DATE DE D		
K 0271 SS=E	NFPA 101 Discharge from E			Administrator will present the inspection results at the month Quality Assurance/Performant Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutiour credible allegation of compliance with all regulatory requirements. Our date of compliance is 5/22/2025.	hly ce J. by n as		

FORM CMS-2567(02-99) Previous Versions Obsolete

Bldg. 01

Event ID:

Y50Q21 Facility ID: 000310

If continuation sheet

Page 10 of 24

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155443		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 01 COMPLETED B. WING 04/22/2025			ETED			
		ROVIDER OR SUPPLIER			2400 C	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)		(X5) COMPLETION DATE
		failed to ensure 1 of level walking surface and constructed of 1 surface in accordant. Certification Letter could affect 13 resident friendings include: Based on observation Maintenance Direct p.m. the exit dischabad large cracks and landing seemed on the hazard. The MD staneed to be repaired. This finding was actime of observation	on and interview with the or (MD) on 04/22/25 at 12:33 rge near Resident Room #404, d was uneven where the sidewalk creating a trip ted that the walkway would	KO	271	K271– It is the intent of the factor to ensure exit discharges have level walking surface, are free obstructions, and constructed hard packed all weather travel surface in accordance with CN Survey and certification letter 05-38 to meet set standards. 1 Corrective Actions Taker a On or before 5/22/2025 the Maintenance Supervisor/designepaired the large crack and uneven area at the landing at sidewalk at the exit discharge near resident room 404 to measet standards. 2 All Others with Potential be Affected: a All residents and all staff and visitors have the potential be affected but none were. 3 Measures to Prevent Reoccurrence: a On 5/05/2025 the Administrator inserviced the Maintenance Supervisor to en exit discharges and walkway a readily accessible to meet set standards. b Maintenance Supervisor/designee will inspeall exit discharge and walkway ensure they are readily access as a part of the facility's Month Preventive Maintenance Progrand document those inspectio results as appropriate. If any issues are discovered, they will seven a progrand document those inspectio results as appropriate. If any issues are discovered, they will seven and they will seven a progrand they will seven and they will seven a progrand they will seven and they will seven a progrand they will seven and	e a for of	05/22/2025

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155443		A. BUILDING B. WING	01	COMPLETED 04/22/2025			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2400 CHATEAU DR MUNCIE, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				addressed and resolved immediately. The Maintenand 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. 4 Monitoring Corrective Action: a The inspection results who be presented by the Maintenan Supervisor/designee to 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 the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitution our credible allegation of compliance with all regulatory requirements. Our date of compliance is on or before 5/22/2025.	ill noce hly ce l. by n as		
K 0321	NFPA 101	Englesses					
SS=E Bldg. 01	Hazardous Areas	- Enclosure					
	1. Based on observa	ation and interview, the facility	K 0321	K321– It is the intent of the fac	oility 05/22/2025		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPL	ETED
		155443	B. W	ING		04/22/	/2025
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	2			HATEAU DR		
\A/ATEDG	OF MUNICIE THE	•			E, IN 47303		
WATERS	S 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	failed to ensure 1 of	f over 10 hazardous area doors,			to ensure hazardous area doo	rs,	
	such as storage room	ms, were provided with			such as storage rooms, are		
	properly working so	elf-closing devices. This			provided with properly working]	
	deficient practice co	ould affect 6 staff and visitors.			self-closing devices and to en	sure	
					furnace rooms on the service	hall	
	Findings include:				that contained fuel fired equip	ment	
					area separated from other spa	ices	
	Based on observation and interview with the				by smoke resistant partition/w	alls	
	Maintenance Director (MD) on 04/22/25 at 1:00				to meet set standards.		
	p.m., the corridor door to the kitchen, greater than				1 Corrective Actions Taker	n:	
	50 square feet and containing large trash				a On 5/06/2025 the		
	receptacles, equipped with a self-closing device				Maintenance Supervisor/desig	jnee	
	failed to latch into the door frame. The kitchen				repaired the self-closing devic	e on	
	staff stated that the door might latch if you leave				the corridor door to the kitcher	n to	
	it alone for a few minutes.				ensure it self closes and latch	es	
					into the door frame to meet se	t	
	This finding was ac	knowledged by the MD at the			standards. The Administrator		
	time of observation	and again at the exit			verified the work on 5/05/2025	j .	
	conference with the	MD and Administrator			b On 5/07/2025 the		
	present.				Maintenance Supervisor/desig	jnee	
					repaired the hole in the service	е	
	2. Based on observa	ation and interview, the facility			hallway furnace wall with a on	е	
	failed to ensure 1 of	f 3 furnace rooms on the			hour fire rated material to ensu	ure	
	service hall that cor	ntained fuel fired equipment			no penetrations to meet set		
	were separated fron	n other spaces by smoke			standards. The Administrator		
	resistant partition/w	valls. This deficient practice			verified the work on 5/07/2025	j.	
	could affect 15 staf	f, residents or visitors.					
					2 All Others with Potential	to	
	Findings include:				be Affected:		
					a All residents and all staff	•	
	Based on observation	on and interview with the			and visitors have the potential	to	
	Maintenance Direct	tor (MD) on 04/22/25 at 1:05			be affected but none were.		
	p.m., the Service H	allway furnace room had a hole					
	approximately 30 in	nches X 12 inches where the			3 Measures to Prevent		
	condensation drain	penetrated the wall, exposing			Reoccurrence:		
	the wall studs.				a On 5/05/2025 the		
	This finding was ac	knowledged by the MD at the			Administrator inserviced the		
	time of observation	and again at the exit			Maintenance Supervisor/ desi	gnee	
	conference with the	MD and Administrator			on the requirement to ensure		
	present.				hazardous areas are provided	with	

PRINTED: 05/22/2025 FORM APPROVED OMB NO. 0938-039

A BUILDING 155443 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 REGULATORY OR LSC IDENTIFYING INFORMATION 3.1-19(b) STREET ADDRESS, CITY, STATE, ZIP COD 2400 CHATEAU DR MUNCIE, IN 47303 (X5) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION 3.1-19(b) STREET ADDRESS, CITY, STATE, ZIP COD 2400 CHATEAU DR MUNCIE, IN 47303 (X5) PREFIX TAG PROVIDERS PLAN OF CORRECTION EXCHANGEMENT AND OF CORRECTION EXCHANGEMENT AND OF CORRECTION EXCHANGEMENT AND OF CORRECTION DATE PREFIX TAG PROVIDERS PLAN OF CORRECTION EXCHANGEMENT AND OF CORRECTION EXCHANGEMENT AND OF CORRECTION DATE PREFIX TAG PROVIDERS PLAN OF CORRECTION EXCHANGEMENT AND OF CORRECTION DATE OUTPOSS PLAN OF CORRECTION EXCHANGEMENT AND OF CORRECTION DATE PREFIX TAG PROVIDERS PLAN OF CORRECTION EXCHANGEMENT AND OF CORRECTION DATE OUTPOSS PLAN OF CORRECTION DATE OUTPOSS PLAN OF CORRECTION EXCHANGEMENT AND OF CORRECTION DATE OUTPOSS PLAN OF CORRECTION DATE OUTPOSS PLAN OF CORRECTION DATE OUTPOSS PLAN OF CORRECTION COMPLETION DATE OUTPOSS PLAN OF CO	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
NAME OF PROVIDER OR SUPPLIER WATERS OF MUNCIE, THE X(4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION PATE AND IDENTIFY IN THE PROVIDERS PLAN OF CORRECTION SUBJECT BY SUPPLIED TO COMPLETION DATE 3.1-19(b) 3.1-19(b) DATE PROVIDERS PLAN OF CORRECTION SUBJECT BY FULL PREFIX TAG PROVIDERS PLAN OF CORRECTION SUBJECT BY FULL PREFIX TAG PROVIDERS PLAN OF CORRECTION SUBJECT BY FULL PREFIX TAG PROVIDERS PLAN OF CORRECTION SUBJECT BY FULL PREFIX TAG PROVIDERS PLAN OF CORRECTION SUBJECT BY PROVIDERS PLAN OF CORRECTION C	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
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WATERS OF MUNCIE, THE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 3.1-19(b) (X5) PROVIDERS PLAN OF CORRECTION (CAST OR PROVIDERS PLAN OF CORRECTION MONIBOURD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF COMPLETION DATE) (X5) PREFIX TAG PROVIDERS PLAN OF CORRECTION MISSIAND BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF COMPLETION DATE (X5) PROVIDERS PLAN OF CORRECTION MISSIAND BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF COMPLETION DATE (X5) PROVIDERS PLAN OF CORRECTION MISSIAND BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF COMPLETION DATE (X5) PROVIDERS PLAN OF CORRECTION MISSIAND BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF COMPLETION DATE (X5) PROVIDERS PLAN OF CORRECTION MISSIAND BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF COMPLETION DATE (X5) PROVIDERS PLAN OF CORRECTION MISSIAND BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF COMPLETION DATE (X5) PROVIDERS PLAN OF CORRECTION MISSIAND BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF COMPLETION DATE (X5) PROVIDERS PLAN OF CORRECTION MISSIAND BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF COMPLETION DATE (X5) PROVIDERS PLAN OF CORRECTION MISSIAND BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF COMPLETION DATE (X5) PROVIDERS PLAN OF CORRECTION MISSIAND BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF COMPLETION DATE (X5) PROVIDERS PLAN OF COMPLETION DATE OF COMPLETION DATE (X5) PROVIDERS PLAN OF COMPLETION DATE	N	DOLUDED OF STREET	n		STREET A	ADDRESS, CITY, STATE, ZIP COD		
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PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION 3.1-19(b) 4.	WATERS	S OF MUNCIE, THE	<u> </u>		MUNCI	E, IN 47303		
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inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance						_	W	
c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance								
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								
Preventative Maintenance								
L decumentation is in place								
documentation is in place.						documentation is in place.		
4 Monitoring Corrective						4 Monitoring Corrective		
Action:						Action:		
a The inspection results will						a The inspection results w	ill	
be presented by the Maintenance						_ ·	nce	
Supervisor/designee to the						_ ·		
Administrator monthly and the						_	:	
Administrator will present the						-		
inspection results at the monthly						T	-	
Quality Assurance/Performance						1		
Improvement (QA/PI) meeting.								
Inspection results and system								
components will be reviewed by						I	by	
the QA/PI Committee with							n	
subsequent plans of correction developed and implemented as						•		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y50Q21 Facility ID: 000310

If continuation sheet

Page 14 of 24

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155443	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(x3) date survey COMPLETED 04/22/2025
	PROVIDER OR SUPPLIER		2400 (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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
				deemed necessary to ensure compliance is maintained. This plan of correction constitution our credible allegation of compliance with all regulatory requirements. Our date of compliance is 5/22/2025.	ites
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and	Electric			
Blug. UT	failed to ensure 2 of corridors were secu personnel. NFPA 70 Energized parts of senclosed as specific specified in 230.62((A) Enclosed. Energized that they will not contact or shall be generally be installed on control board and generally 110.18 and 110.27. guarded as provided means for locking coaccess to energized	on and interview, the facility of over 8 electrical panels in the red from non-authorized (2), 2011 edition states 230.62 dervice equipment shall be ad in 230.62(A) or guarded as (B). Gized parts shall be enclosed to be exposed to accidental guarded as in 230.62(B). Gized parts that are not enclosed to a switchboard, panelboard, or uarded in accordance with Where energized parts are the in 110.27(A)(1) and (A)(2), a part sealing doors providing parts shall be provided. This build affect 15 staff and	K 0511	K511– It is the intent of the fact to ensure electrical panels in the corridors are secured from non-authorized personnel to meet standards. Corrective Action Taken: a On 4/22/2025 the Maintenance Supervisor/design locked the two electrical panel near resident room 407 to meet set standards. The Administrativerified the work on 4/22/2025 All Others with Potential be Affected: a All residents and all staff and visitors have the potential be affected but none were. Maintenance Supervisor check all other areas and found no or negative findings.	neet neet neet s et ator . to to
	Maintenance Direct p.m., two electrical 407 were unlocked	on and interview with the or (MD) on 04/22/25 at 12:25 panels near Resident Room # when tested. The MD was		3 Measures to Prevent Reoccurrence: a On 4/22/2025 the Administrator inserviced the	
		panels were not locked. knowledged by the MD at the		Maintenance Supervisor/desig on the requirement to ensure electrical panels in the corridor	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRAND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>0</u> B. WING		onstruction 01	(X3) DATE SURVEY COMPLETED 04/22/2025				
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
WATERS	OF MUNCIE, THE				HATEAU DR E, IN 47303		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		and again at the exit	+	IAG	are secured from non-personr	nel to	DATE
		MD and Administrator			meet set standards.		
	present.				b Maintenance		
					Supervisor/designee will ensu		
	3.1-19(b)				electrical panels in the corrido		
					are secured from non-personr a part of the facility's weekly	iei as	
					Preventive Maintenance Prog	ram	
					and document those inspection		
					results as appropriate. If any		
					issues are discovered, they w	ill be	
					addressed and resolved		
					immediately. The Maintenand		
					Supervisor/designee will revie with the Administrator the	W	
					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		
					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/Performan	•	
					Improvement (QA/PI) meeting		
					Inspection results and system		
					components will be reviewed	by	
					the QA/PI Committee with subsequent plans of correctio	n	
					developed and implemented a		
					deemed necessary to ensure		
					compliance is maintained		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155443		(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 04/22/2025
	PROVIDER OR SUPPLIER S OF MUNCIE, THE	2400 C	ADDRESS, CITY, STATE, ZIP COD CHATEAU DR IE, 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
			This plan of correction constitution our credible allegation of compliance with all regulatory requirements. Our date of compliance is 5/22/2025.	utes
K 0521 SS=F Bldg. 01	NFPA 101 HVAC			
Dlug. U1	Based on observation and interview, the facility failed to ensure egress corridors were not used as a portion of a return air system serving adjoining rooms for 52 of 52 resident rooms in the egress corridors. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment to be installed in accordance with NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilating Systems. NFPA 90A, Section 4.3.12.1.1 states egress corridors in nursing and long term care facilities shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas unless otherwise permitted by 4.3.12.1.3.1 through 4.3.12.1.3.4. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on observation and interview with the Maintenance Director (MD) on 04/22/25 at 12:10 p.m. and observations throughout the afternoon during the facility tour, all resident rooms were using the egress corridor as a return air system. Based on interview at the time of the observations, the MD verified the resident rooms were using the egress corridor as a return air system. The MD commented, "heat in the resident	K 0521	K521 – The facility has submitted an annual waiver request. Documentation has been uplo to include waiver request, floo plan, and documentation of hardship.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y5OQ21 Facility ID: 000310

If continuation sheet

Page 17 of 24

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u>	COMPL	
		155443	B. W	ING		04/22/	2025
	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)	16	DATE
	supply register in ear	ach resident room and no					
	time of observation	knowledged by the MD at the and again at the exit MD and Administrator					
	3.1 15(0)						
K 0761	NFPA 101						
SS=E Bldg. 01	Maintenance, Insp	pection & Testing - Doors					
Didg. 01	interview, the facilit inspection and testin assembly was comp 19.1.1.4.1.1 commu fire barriers required permitted only in comparities by approved self-cle (See also Section 8. required to have a fix 8.3.4.2 shall be protabled fire door assemblies and their including all frames and sills in accordant NFPA 80, Standard Opening Protectives specified in this Cordoor assemblies shalless than annually, a inspection shall be sides to assess the of assembly. NFPA 80, the following items	on, records review, and ty failed to ensure annual and of at least 1 fire door eleted in accordance of LSC unicating openings in dividing d by 19.1.1.4.1 shall be portions and shall be protected osing fire door assemblies. 3.) LSC 8.3.3.1 Openings in protection rating by Table elected by approved, listed, semblies and fire window accompanying hardware, accompanyin	K 0	761	K761 – It is the intent of the facility to ensure an annual inspection and testing of at least 1 fire door assembly is completed in accordance with LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies to meet set standards. 1 Corrective Actions Taken: a On 5/07/2025the Maintenance Supervisor conducted the annual inspection of the oxygen transfilling room fire door assembly and documented the results in the Life Safety Binder to meet set standards. The Administrator verified the work on 5/07/2025.		05/22/2025

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y50Q21 Facility ID: 000310

If continuation sheet Page 18 of 24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155443		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/22/2025		
	PROVIDER OR SUPPLIER			2400 C	ADDRESS, CITY, STATE, ZIP COD HATEAU DR IE, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE .	DATE
	either the door or fr				be affected but none were.		
	(2) Glazing, vision	light frames, and glazing beads					
		ely fastened in place, if so			3 Measures to Prevent		
	equipped.	1 /			Reoccurrence:		
		e, hinges, hardware, and			a On 5/05/2025 the		
		eshold are secured, aligned,			Administrator inserviced the		
		er with no visible signs of			maintenance Supervisor to er	sure	
	damage.				an annual inspection and testi		
	(4) No parts are missing or broken.				of oxygen room fire door asse	-	
	* / *	s do not exceed clearances			is completed and documented	-	
	listed in 4.8.4 and 6				meet set standards.		
	(6) The self-closing device is operational; that is,				b Maintenance		
	the active door completely closes when operated				Supervisor/designee will ensu	re an	
	from the full open position.				annual inspection and testing		
	(7) If a coordinator is installed, the inactive leaf				oxygen room fire door asseml		
	closes before the ac				completed and documented a	-	
		are operates and secures the			part of the facility's annual	Ju	
	door when it is in the				Preventive Maintenance Prog	ram	
		vare items that interfere or			and document those inspection		
		are not installed on the door or			results as appropriate. If any		
	frame.				issues are discovered, they w		
		fications to the door assembly			addressed and resolved	50	
		ed that void the label.			immediately. The Maintenance	e.	
	_	edge seals, where required, are			Supervisor/designee will revie		
		their presence and integrity.			with the Administrator the	"	
		ice could affect 14 residents.			inspection results.		
	1				c The Administrator will		
	Findings include:				monitor adherence to the		
					Preventative Maintenance		
	Based on records re	eview, interview and facility			schedule and validate the		
		enance Director (MD) on			Preventative Maintenance		
		.m., no documentation of an			documentation is in place.		
		or the fire door assembly at the					
		g room was available for review.			4 Monitoring Corrective		
		on during the tour the Oxygen			Action:		
		as one 90-minute fire door			a The inspection results w	rill l	
		interview at the time of			be presented by the Maintena		
		observation, the Maintenance			Supervisor/designee to the		
		ne annual fire door inspection			Administrator monthly and the	,	
	-	within the last year and was			Administrator will present the		

PRINTED: 05/22/2025 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155443	(X2) MUL A. BUIL B. WINC	DING	nstruction 01	(X3) DATE : COMPL 04/22 /	ETED
	PROVIDER OR SUPPLIER] ;	2400 CH	DDRESS, 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 LISC IDENTIFYING INFORMATION	PF	ID REFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ë	(X5) COMPLETION DATE
	needed on the Trans This finding was ac time of observation	a fire door inspection was sfilling Room door. knowledged by the MD at the and again at the exit MD and Administrator			inspection results at the month Quality Assurance/Performand 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 a deemed necessary to ensure compliance is maintained. This plan of correction constitutiour credible allegation of compliance with all regulatory requirements. Our date of compliance is 5/22/2025.	e y s	
K 0921 SS=F Bldg. 01	interview, the facili required maintenand documentation of ir Related Electrical E 2012 edition, section physical integrity, respectively touch current tests for is performed as requare established with PCREE used in patriaccordance with 10 into service and after Any system consist appliances demonst 99 as a complete syinstructions, and promanufacturer include.	ent - Testing and view, observation, and ty failed to conduct the ce and maintain complete aspections for Patient Care equipment (PCREE). NFPA 99 ans 10.3 and 10.5 states the esistance, leakage current, and for fixed and portable PCREE uired in 10.3. Testing intervals a policies and protocols. All tent care rooms is tested in a.3.5.4 or 10.3.6 before being put er any repair or modification. ting of several electrical rates compliance with NFPA stem. Service manuals, ocedures provided by the de information as required by onsidered in the development	K 092	:1	K921 – It is the intent of the facility to ensure to conduct the required maintenance and maintain complete documentar of inspections for Patient Care Related Electrical Equipment (PCREE) to meet set standard Corrective Actions Taken: On or before 5/16/2025 the facilities trained Regional Prop Managers will conduct PCREE testing on the other PCREE in facility including; electric beds, nebulizers, oxygen concentrate vital sign monitors, and other electrical medical equipment to meet set standards. The Administrator verified the work 5/16/2025 or before.	erty the ors,	05/22/2025

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y5OQ21 Facility ID: 000310

If continuation sheet Page 20 of 24

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155443	B. WI	NG		04/22/	2025
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			HATEAU DR		
WATERS	OF MUNCIE, THE	:			E, IN 47303		
(X4) ID	SHIMMADV	STATEMENT OF DEFICIENCIE		ID		1	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
5		ectrical equipment maintenance.	+				=====
		nt instructions and maintenance			All Others with Potential to be		
		available, and safety labels			Affected:		
	-	rating instructions on the			All residents and all staff and		
	-	e. A record of electrical			visitors have the potential to b	e	
	equipment tests, repairs, and modifications is				affected but none were.		
		riod of time to demonstrate			Measures to Prevent		
	compliance in accordance with the facility's				Reoccurrence:		
	policy. Personnel responsible for the testing,				On 5/05/2025 the Administrate	or	
	maintenance and us	e of electrical appliances			inserviced the Maintenance		
	receive continuous	training. This deficient			Supervisor/DON/designee to		
	practice affects all residents.				ensure the testing of the PCR	EE	
					is conducted and documented	l on	
	Findings include:				all PCREE equipment to meet	set	
					standards.		
		view, interview and facility					
		enance Director (MD) on			Maintenance Supervisor/desig		
		.m., no documentation was			will ensure testing of the PCR		
		for the testing of the PCREE in			is conducted and documented		
	-	facility, as required by section			all PCREE equipment as a pa		
		9, Health Care Facilities Code.			the facility's annual Preventive	•	
	_	the building tour throughout			Maintenance Program and		
		led that the facility provided			document those inspection res		
		residents. The MD stated that			as appropriate. If any issues a		
		pulizers, oxygen concentrators,			discovered, they will be addre		
		, and other electrical medical			and resolved immediately. The		
	equipment was pres	sent and in use at the facility.			Maintenance Supervisor/desig		
	This for the	Imperiod and her the MD 4.4			will review with the Administra	itor	
	-	knowledged by the MD at the			the inspection results.		
		and again at the exit MD and Administrator			The Administrator will monitor		
		and Administrator			adherence to the Preventative Maintenance schedule and	;	
	present.				validate the Preventative		
	3.1-19(b)				Maintenance documentation is	s in	
	J.1-17(U)					5 111	
					place. Monitoring Corrective Action;		
					The inspection results will be		
					presented by the Maintenance	<u> </u>	
					Supervisor/designee to the	,	
					Administrator monthly and the	,	
			1		I Authinionator monthly and the		

PRINTED: 05/22/2025 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER 155443	A. BUILDING B. WING	01	COMPLETED 04/22/2025
	ROVIDER OR SUPPLIER OF MUNCIE, THE		2400 C	ADDRESS, CITY, STATE, ZIP COD HATEAU DR E, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - 1 Based on observation failed to ensure 1 of location was used provided by the NFPA 99. NFF Code, 2012 Edition, (transfilling shall occupanted from any patients are housed, barrier of 1 hour firm NFPA 99 2012 edition transfilling the contrained in the transfilling the co	Fransfilling Cylinders on and interview, the facility of 1 oxygen storage/transfer roperly and in accordance of A 99, Health Care Facilities of Section 11.5.2.3.1(1) states, occur in) a designated area portion of a facility wherein examined, or treated by a fire e-resistive construction. fon, 11.5.2.3.1 (4) the individual tainer(s) has been properly filling procedures. This ould affect up to 20 residents in	K 0927	Administrator will present the inspection results at the month Quality Assurance/Performand Improvement (QAPI) meeting. Inspection results and system components will be reviewed by the QAPI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitution our credible allegation of compliance with all regulatory requirements. Our date of compliance is 5/22/2025. K927– It is the intent of the fact to ensure oxygen storage/translocation is used properly and it accordance with NFPA 99 to reset standards. Corrective Actions Takes and On 5/06/2025 the DON/Maintenance Supervisor reconfigured the oxygen room allow for oxygen transfer to take place with door closed to mee standards. The Administrator verified the work on 5/06/2025.	cility of see on the see of the s
	one smoke comparts Findings include:	-		2 All Others with Potential be Affected:	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y5OQ21 Facility ID: 000310

If continuation sheet

Page 22 of 24

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155443	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/22/2025
	PROVIDER OR SUPPLIER		2400 C	ADDRESS, CITY, STATE, ZIP COD CHATEAU DR IE, IN 47303	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION DATE
	Maintenance Direct p.m., the facility's C populated with liqu did not appear to be transfilling procedu door closed. When how they would act they held the door commented that the do the transfilling p the door closed. This finding was act time of observation	on and interview with the tor (MD) on 04/22/25 at 12:39 Daygen Room was small and id oxygen containers. There is room for someone to do the are inside the room with the asked, a QNA demonstrated complish the procedure, and open with their leg. The QNA is room was not large enough to procedure inside the room with the and again at the exit is MD and Administrator.		a All residents and all stand visitors have the potention be affected but none were. 3 Measures to Prevent Reoccurrence: On 5/05/2025 the Administrinserviced the DON/and all istaff/Maintenance Supervisor ensure door is able to be in closed position when transfi occurring to meet set standad Maintenance Supervisor/DO ensure door is able to be in closed position when transfi occurring as a part of the fact Oxygen Policy and Procedu and document those inspectives as appropriate. If any issues are discovered, they addressed and resolved immediately. The Maintenar Supervisor/DON/designee wereview with the Administrator inspection results. On 4 Monitoring Corrective A a The inspection results. On 4 Monitoring Corrective A a The inspection results at the more Quality Assurance/Performate Improvement (QA/PI) meeting Inspection results and systecomponents will be reviewed the QA/PI Committee with	rator nursing or to the Illing is ards. N will the Illing is cility's res tions / will be ace // will be ace // will be ace // will in the

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/22/2025 FORM APPROVED OMB NO. 0938-039

CENTERSFOR	MEDICARE & MEDIC	AID SERVICES			OM	B NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPL	ETED
		155443	B. WING		04/22/	/2025
	ROVIDER OR SUPPLIER		2400 C	ADDRESS, CITY, STATE, ZIP COD HATEAU DR E, 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 APPROPRIAT	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
				subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutiour credible allegation of compliance with all regulatory requirements. Our date of compliance is 5/22/2025.	S	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: Y5OQ21 Facility ID: 000310 If continuation sheet Page 24 of 24