

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/14/2015
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NAME OF PROVIDER OR SUPPLIER  MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
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K 0000  Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/14/15</p> <p>Facility Number: 011150 Provider Number: 155760 AIM Number: 200831020</p> <p>At this Life Safety Code survey, Maples At Waterford Crossing was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, areas open to the corridors and the resident rooms. The facility has a capacity of 87 and had a census of 67 at the time of this survey.</p>	K 0000	<p>The preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Life Safety Code Recertification and State Licensure Survey on July 14, 2015. Please accept this Plan of Correction as The Maples at Waterford Crossing's credible allegation of compliance effective August 13, 2015. The Maples at Waterford Crossing respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>	

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 0029 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 kitchen doors latched into the door frame. This deficient practice could affect staff and all residents in the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations on 07/14/15 at 1:57 p.m., the one door going in and out of the kitchen to the dining room did not latch into the door frame. Based on interview at the time of observation, the Director of Plant Operations acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>	K 0029	<p>1. Director of Plant Operations (DPO) adjusted closer on kitchen door cited to latch properly. 2. This alleged deficient practice has the potential to affect all residents. 3. All other applicable doors reviewed to ensure there are means suitable for keeping door closed. DPO or designee will review at least monthly on preventative maintenance schedule the self closing feature of doors including kitchen. 4. Trends will be brought to monthly Quality Assurance meeting for review by QA committee for six months or until 100% compliance is achieved.</p>	08/13/2015	
K 0044 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 fire door sets in the Service Hall was arranged to</p>	K 0044	<p>1. DPO adjusted latch on service hall fire barrier door to latch properly. 2. This alleged deficient practice has the potential to affect</p>	08/13/2015	

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K 0069 SS=E Bldg. 01	<p>automatically close and latch. LSC requires 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice affects staff and 36 residents on the 200 Hall.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Plant Operations on 07/14/15 at 11:46 a.m., the Service Hall fire barrier doors did not latch into the frame when tested. Based on interview at the time of observation, the Director of Plant Operations acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 18.3.2.6, NFPA 96 Based on observation and interview, the facility failed to protect cooking</p>	K 0069	<p>all residents. 3. All other applicable fire barrier doors reviewed to ensure they close and latch properly. DPO or designee will review at least monthly on preventative maintenance schedule that all fire barrier doors close and latch properly. 4. Trends will be brought to monthly Quality Assurance meeting for review by QA committee for six months or until 100% compliance is achieved.</p> <p>1. Therapy staff re-educated during</p>	08/13/2015

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	<p>equipment with a range hood extinguishing system in accordance with LSC Sections 9.2.3 and 19.3.2.6 and NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations in 1 of 1 Therapy kitchens. NFPA 96, 7-1.2 requires cooking equipment that produces grease laden vapors (such as but not limited to deep fat fryers, ranges, griddles, broilers, woks, tilting skillets, and braising pans) shall be protected by fire extinguishing equipment. This deficient practice could affect any resident, as well as staff and visitors in Therapy.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations on 07/14/15 at 11:56 a.m., a Program Director was observed cooking ground beef on the stovetop in the Therapy kitchen under a range hood that lacked an extinguishing system. Based on interview at the time of observation, the Program Director said they do sometimes also cook eggs and sausage. The Director of Plant Operations acknowledged the pantry range hood was not provided with an extinguishing system.</p> <p>3.1-19(b)</p>		<p>survey and stopped cooking grease laden foods. 2. This alleged deficient practice has the potential to affect all residents. 3. Therapy staff re-inserviced on not cooking grease laden foods given the lack of fire extinguishing equipment in that area. DPO or designee will observe therapy staff cooking three times per week for six months to ensure they are not cooking grease laden foods. 4. Trends will be brought to monthly Quality Assurance meeting for review by QA committee for six months or until 100% compliance is achieved.</p>				

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K 0130 SS=F Bldg. 01	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure the penetration in 1 of 4 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p>	K 0130	<p>1. DPO will fire caulk the penetrations cited in 200 and 300 hall fire barriers. 2. This alleged deficient practice has the potential to affect all residents. 3. DPO or designee will monitor and inspect fire barriers monthly to ensure that penetrations remain fire caulked. 4. Trends will be brought to monthly Quality Assurance meeting for review by QA committee for six months or until 100% compliance is achieved.</p>	08/13/2015
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K 0147 SS=D Bldg. 01	<p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect residents in 3 of 4 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Plant Operations on 07/14/15 at 12:53 p.m. then again at 1:03 p.m., the 200 Hall fire barrier had an unsealed penetration measuring one quarter inch around conduit, then again the 300 Hall fire barrier had an unsealed penetration measuring one quarter inch around conduit. Based on interview at the time of each observation, the Director of Plant Operations acknowledged the aforementioned conditions.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 extension cord, 1 of 1 multiplug adapter were not</p>	K 0147	1. Extension cord in administrator office removed. Multiplug adapter in payroll office was removed and	08/13/2015

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	<p>used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects 5 residents at the nurse's station.</p> <p>Findings include:</p> <p>Based on observation with Director of Plant Operations on 07/14/2015 twice at 12:15 p.m. an extension cord was plugged into a surge protector powering a fan in the Executive Director's office. Then again a multiplug adapter was powering computer components and another surge protector in the Payroll office. Based on interview at the time of each observation, the Director of Plant Operations acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p>		<p>surge protector put in place. 2. This alleged deficient practice has the potential to affect all residents. 3. Staff re-inserviced on proper use of electrical wiring and equipment. DPO or designee will audit office areas weekly to ensure proper use of electrical wiring and equipment. 4. Trends will be brought to monthly Quality Assurance meeting for review by QA committee for six months or until 100% compliance is achieved.</p>	