

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 08/21/2015
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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 07/14/15 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/21/15</p> <p>Facility Number: 011150 Provider Number: 155760 AIM Number: 200831020</p> <p>At this PSR survey, Maples At Waterford Crossing was found in substantial 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</p>	K 0000		

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 0044 SS=B Bldg. 01	<p>facility has a capacity of 88 and had a census of 65 at the time of this survey.</p> <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 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 08/21/15 at 9:57 a.m., Service Hall fire barrier doors were tested to latch into the frame. One door latched into the frame, the other door closed but did not fully latch. Based on interview at the time of observation,</p>	K 0044	<p>1. Director of Plant Operations (DPO) adjusted latch on service hall fire barrier door to latch properly. 2. This alleged deficient practice has the potential to affect all residents. 3. All other applicable fire barrier doors reviewed to ensure they close and latch properly. Director of Plant Operations (DPO) or designee will review at least <u>weekly</u> 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>	08/25/2015

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	the Director of Plant Operations acknowledged the aforementioned condition. 3.1-19(b)				