

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155199	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/15/2014
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NAME OF PROVIDER OR SUPPLIER MAPLE PARK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 776 N UNION ST WESTFIELD, IN 46074
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K010000	<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: 05/15/14</p> <p>Facility Number: 000106 Provider Number: 155199 AIM Number: 100266390</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Maple Park Village 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 19, Existing 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 smoke detection in the corridors, in spaces open to the corridors and battery powered smoke detectors in resident rooms. The facility has a</p>	K010000	<p>May 22 2014, Dear Kim Rhoades, Please find the attached Plan of Corrections for the Life Safety Code survey ID # 2QHB21 performed on May 15th, 2014. Attached you will find visual and paper confirmation of all rectified deficiencies. The provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a desk review, in lieu of a Post Survey revisit. Sincerely, Zach Krumwied, HFA Executive Director Maple Park Village The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p>	
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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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K010029 SS=E	<p>capacity of 106 and had a census of 103 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for two detached storage buildings.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/20/14/</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied</p>			

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	<p>protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 5 of 12 doors to hazardous areas such as the kitchen, laundry and areas containing combustible items such as central supply and the conference room would self close and latch securely into its frame. This deficiency could affect 16 residents on 300 hall north, 18 residents on 100 north and 21 residents on 200 north as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observations on 05/15/14 during the tour between 1:45 p.m. to 2:30 p.m. with the Maintenance Supervisor, the following doors either did not latch into the frame or were not provided with a door closure.</p> <ol style="list-style-type: none"> 1. The east and west kitchen doors adjacent to 300 hall north did not latch into their frames. 2. The laundry room door on 100 hall north did not latch into its frame. 3. The door to the central supply room which was over fifty square feet in size and contained fifteen boxes would not latch into its frame. 4. The door to the conference room which was over fifty square feet in size 	K010029	<p>K 029</p> <ol style="list-style-type: none"> 1.No residents were identified as being affectedby the deficient practice. 2.55 Residents were identified as having thepotential to be affected by this deficient practice. The east and west kitchen doorsadjacent to the 300 hall north, the laundry room door on hall 100, and thecentral supply door were all repaired to ensure that they self close and latchsecurely to their frame. The door to the conference room was equipped with a self-closing device to ensure that it self-closes and latches securely to itsframe. 3. Afacility audit was performed to ensure that all doors hazardous areas selfclose and latch securely to their frames. 4.The Maintenance director will perform weeklyaudits to ensure that all doors to hazardous areas self-close and latchsecurely to their frames. 	05/22/2014

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K010045 SS=E	<p>and contained thirty six boxes was not equipped with a closing device. Based on interview on 05/15/14 concurrent with the observations with the Maintenance Supervisor, it was acknowledged the aforementioned hazardous area doors were either not latching into their frame or were not provided with a self closing device to ensure the doors would close and latch without assistance.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>Based on observation and interview, the facility failed to ensure the lighting in 1 of 10 exit means of egress was arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. LSC Section 7.8.1.4 requires illumination be arranged so the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area. This deficient practice could affect 43 residents on 200 north and south halls as well as staff and visitors if the facility</p>	K010045	<p>K 045</p> <p>1.No residents were identified as being affectedby the deficient practice.</p> <p>2.43 Residents were identified as having the potentialto be affected by this deficient practice. The lighting outside the backentrance which serves as the primary exit for hall 200 residents was replacedwith a dual bulb fixture to ensure that the failure of any single lighting fixturedoes not result in an illumination level of less than .2 ft-candle in any designatedarea.</p>	05/22/2014

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	<p>were required to evacuate and the single bulb outside failed leaving the area in darkness.</p> <p>Findings include:</p> <p>Based on observation on 05/15/14 at 2:45 p.m. with the Maintenance Supervisor, an exit light on generator back up was located outside the back entrance which serves as a primary exit for the residents on 200 north and south halls only had a single bulb in the light fixture. Based on interview on 05/15/14 at 2:50 p.m. it was acknowledged by the Maintenance Supervisor, the outside light providing illumination for the exit discharge out of the back exit was equipped with only a single bulb light fixture.</p> <p>3.1-19(b)</p>		<p>3.A facility audit was performed to ensure that all illumination is arranged so that the failure of any single lighting fixture does not result in an illumination level of less than .2 ft-candle in any designated area.</p> <p>4. The Maintenance director will perform weekly audits to ensure that all illumination is arranged so that the failure of any single lighting fixture does not result in an illumination level of less than .2 ft-candle in any designated area.</p>				
K010062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation, record review and interview; the facility failed to ensure 3 of 3 pressure gauges for the sprinkler</p>	K010062	<p>K 062 1. All residents, occupants, and staff were identified as being</p>	05/22/2014			

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	<p>system in the Riser room were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on observation on 05/15/14 at 1:38 p.m. with the Maintenance Supervisor, three pressure gauges in the sprinkler riser room next to the back entrance on 200 hall had manufacturer's dates of 2008. Based on Sprinkler Inspection Records review on 05/15/14 at 4:15 p.m. with the Maintenance Supervisor, documentation did not reveal the sprinkler system gauges had been calibrated since that date. Based on interview on 05/15/14 concurrent with the observation it was acknowledged by the Maintenance Supervisor the pressure gauges had exceeded the five year requirement for recalibration or replacement.</p> <p>3.1-19(b)</p>		<p>affected by this deficient practice. The 3 identified pressure gauges on in the sprinkler riser room next to the back entrance were calibrated to ensure that the system is maintained in reliable operating condition.</p> <p>2. All residents were identified as being affected by this deficient practice. The 3 identified pressure gauges on in the sprinkler riser room next to the back entrance were calibrated to ensure that the system is maintained in reliable operating condition.</p> <p>3. The Maintenance director performed a facility audit to ensure that the automatic sprinkler systems area being maintained in reliable condition and are inspected and tested periodically.</p> <p>4. The Maintenance director will perform facility audit monthly to ensure that the automatic sprinkler systems area being maintained in reliable condition and are inspected and tested periodically.</p>	

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K010147 SS=E	<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 surge protectors, including extension cords, non-fused extension cords and/or multiplug adapters were not used as a substitute for fixed wiring. NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 2 residents in room # 304, as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 05/15/14 at 1:11 p.m. with the Maintenance Supervisor, a surge protector was used to provide power to medical equipment such as a power lift chair in resident room # 304 instead of directly plugging the chair into a wall outlet. Based on interview on 05/15/14 at 1:12 p.m. it was acknowledged by the Maintenance Supervisor, a surge protector was used</p>	K010147	<p>K 147</p> <p>1.No Residents were identified as being affectedby this deficient practice.</p> <p>2.2 Residents were identified as having the potential be affected bythis deficient practice. The chair identified as being attached to a surgeprotector to provide power was plugged directly into a wall outlet with fixedwiring.</p> <p>3.The Maintenance director performed a facilityaudit to ensure that no surge protectors, including extension cords, non-fused extensioncords, and/or multi-plug adapters are not being used as a substitute for fixedwiring.</p> <p>4.The Maintenance director/designee will perform afacility audit weekly to ensure that no surge protectors, including extensioncords, non-fused extension cords, and/or multi-plug adapters are not being usedas a substitute for fixed wiring.</p>	05/22/2014

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	for the power lift chair . 3.1-19(b)			