

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 09/03/2013
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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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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: 09/03/13</p> <p>Facility Number: 011150 Provider Number: 155760 AIM Number: 200831020</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Maples At Waterford Crossing Health 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, in areas open to the corridors and in the resident rooms.</p>	K010000	<p>This is the requested Plan of Correction for the Life Safety Code Recertification and State Licensure Survey. The survey was conducted on September 3, 2013 (09/03/2013) for facility number 011150. This constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by state and federal law. The Maples at Waterford Crossing Health Campus desires this Plan of Correction to be considered as the facility's allegation of compliance. Compliance effective September 15, 2013. The Maples at Waterford Crossing Health Campus respectfully requests this Plan of Correction be submitted as desk review for compliance for the deficiencies cited.</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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	<p>The facility has a capacity of 88 and had a census of 60 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/05/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 24 resident rooms on 300 hall had corridor doors that closed and latched into the door frame. This deficient practice could affect 37 residents on the 300 hall.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations on 09/03/13 at 12:50 p.m., the corridor door to resident room 323 failed to latch into the door frame. Based on an interview with the Director of Plant Operations at the time of observation, the bottom hinges needed to be tightened in order for the door to latch into the frame.</p> <p>3.1-19(b)</p>	K010018	<p>It is the intent of The Maples at Waterford Crossing to meet the Life Safety Code Standard so doors protecting corridor openings are constructed to resist the passage of smoke. 1. The corridor to room 323 bottom hinges were adjusted on 9/3/13. At that time the door did close and latch into the frame properly. 2. Upon review by the Director of Plant Operations, the Campus Support for Plant Operations and the Executive Director, no other doors protecting the corridor openings were found to be deficient in this nature. 3. The deficiency was evaluated related to system, education and compliance. Managers including the Director of Plant Operations were educated to check doors protecting corridor openings to assure they are closing and latching properly during their rounding of the campus daily. 4. The Director of Plant Operations will place the task of auditing the doors protecting corridor openings on his preventative maintenance schedule to assure they are closing and latching properly to resist the passage of smoke.</p>	09/09/2013			

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			The results of these audits will be submitted to the Quality Improvement Committee for review each month. 5. Results from these audits will be reported to the QI (Quality Improvement) Committee. Audits will be conducted on a regular basis each month. These audits will continue as stated, or until the QI committee determines otherwise due to the outcome of the audits.	

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K010029 SS=E	<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>1. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 central supply rooms used to store combustibles measuring over 50 square feet in size and 1 of 1 soiled utility rooms on the 300 hall were provided with a self closing device. This deficient practice could affect 37 residents on the 300 hall and facility staff in the central supply room.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations on 09/03/13 from 12:55 p.m. to 1:30 p.m. the following was noted:</p> <p>a. there was no self closer on the corridor door to the central supply room which measured 231 square feet in size and contained 26 cardboard boxes of resident records and other documentation. Measurements were provided by the Director of Plant Operations at the time of observation.</p> <p>b) the 300 hall soiled utility room was designed with double corridor doors.</p>	K010029	<p>It is the intent of The Maples at Waterford Crossing to meet the Life Safety Code Standard so areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door without windows. 1a. The corridor door to the Central Supply Room was fitted with a self-closing(spring) hinge on 9/6/13. 1b. A Smoke Seal was ordered to close the identified gap between the doors. 1c. The left side door has been secured to close permanently with a steel bracket. 1d. The door entering the kitchen as mentioned now has a latching handle as was suggested. The deadbolt is removed and the new latching handle is installed. 2. Upon review by the Director of Plant Operations, the Campus Support for Plant Operations and the Executive Director , no other doors protecting the corridor openings were found to be deficient in this nature. 3. The deficiency was evaluated related to system, education and compliance. Managers including the Director of Plant Operations were educated to check doors</p>	09/23/2013			

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	<p>Neither door was equipped with a self closing device and there was a gap between the doors when closed that measured three sixteenth of a inch at the top and five sixteenth of an inch at the bottom. Additionally, one door was equipped with a manual latching device that would latch into the door frame and the remaining door was designed to latch into the stationary door. Each door could not latch automatically, and independent of the other door, into the door frame. Based on an interview with the Director of Plant Operations at the time of observation, soiled linen barrels are stored in the 300 hall soiled utility room until they are taken to the laundry room.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 2 doors entering the kitchen, a hazardous area, was self closing and latched into the door frame. This deficient practice could affect at least 25 residents in the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations on 09/03/13 at 1:35 p.m., the door entering the kitchen from the main dining room was a swinging</p>		<p>protecting corridor openings to assure they are closing and latching properly during their rounding of the campus daily.</p> <p>4. The Director of Plant Operations will place the task of auditing the doors protecting corridor openings on his preventative maintenance schedule to assure they are closing and latching properly to resist the passage of smoke. The results of these audits will be submitted to the Quality Improvement Committee for review each month. 5. Results from these audits will be reported to the QI (Quality Improvement) Committee. Audits will be conducted on a regular basis each month. These audits will continue as stated, or until the QI committee determines otherwise due to the outcome of the audits.</p>				

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	<p>door which was equipped with only a dead bolt. Based on an interview with the Director of Plant Operations at the time of observation, the door was a nonlatching swinging door to allow food trays and carts easy access to the kitchen.</p> <p>3.1-19(b)</p>			

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K010038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1</p> <p>Based on observation and interview, the facility failed to ensure exit access was arranged so 1 of 7 exits was readily accessible at all times in accordance with LSC Section 7.1. LSC Section 7.1 requires means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.7.1 requires all exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. In addition to providing the required width to allow all occupants safe access to a public way, such access also needs to meet the requirements with respect to maintaining the means of egress free of obstructions that would prevent its use, such as snow and the need for its removal in some climates or soft ground during heavy periods of rain. This deficient practice could affect any of the 37 residents on the 300 hall any of the 9 residents on the 200 hall evacuated through the Garden room exit in the event of an emergency.</p> <p>Findings include:</p>	K010038	<p>It is the intent of The Maples at Waterford Crossing to meet the Life Safety Code Standard so that exits are readily accessible at all times. 1a. The identified door does not have a lighted exit sign as it is NOT an emergency exit and is NOT identified as an emergency exit on our Emergency Plan and NOT identified as an Emergency Exit on any evacuation plan and/or Emergency Route. The printed language on the door identifying it as an Emergency Exit was in error and was removed on 09/3/2013. 1b. The identified door now has signage on the door that reads "Not a Fire Exit" 2. Upon review by the Director of Plant Operations, the Campus Support for Plant Operations and the Executive Director, no other exit doors were found to be out of compliance. 3. The deficiency was evaluated related to system, education and compliance. Managers including the Director of Plant Operations were educated to check exit doors daily during rounding to assure door paths were clear and readily accessible. 4. The Director of Plant Operations will place the task of auditing the exit doors for clear and accessible pathway on his preventative maintenance</p>	09/23/2013			

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	<p>Based on observation with Director of Plant Operations on 09/03/13 at 12:40 p.m., there was an emergency exit sign on the exit door leading outside from the Garden Room. There was a small concrete patio which terminated on a stretch of grassy lawn measuring 100 feet to the Therapy exit discharge sidewalk. Measurements were provided by the Director of Plant Operations at the time of observation.</p> <p>3.1-19(b)</p>		<p>schedule. The results of these audits will be submitted to the Quality Improvement Committee for review each month.</p> <p>5. Results from these audits will be reported to the QI (Quality Improvement) Committee. Audits will be conducted on a regular basis each month. These audits will continue as stated, or until the QI committee determines otherwise due to the outcome of the audits.</p>		

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K010061 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 automatic sprinkler system control valves were supervised. NFPA 101, 19.3.5.2 requires the sprinkler system to be in accordance with 9.7, electrically connected to the fire alarm system and to be fully supervised. 9.7.2.1 requires supervisory attachments shall be installed and monitored for integrity and a distinctive supervisory signal shall be provided to indicate a condition which would impair the satisfactory operation of the sprinkler system. Monitoring shall include control valves. Supervisory signals shall sound and be displayed either at a location in the protected building that is constantly attended by qualified personnel or at an approved remotely located receiving facility. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations on 09/03/13 at 1:55 p.m., the two water control valves for the sprinkler system were secured in the open position with a chain and a padlock.</p>	K010061	<p>It is the intent of The Maples at Waterford Crossing to meet the Life Safety Code Standard so it is ensured that the automatic sprinkler control valves are supervised so a local alarm will sound when the valves are closed. 1a. Koorsen Fire and Security have been contacted to install a supervisory alarm. The alarm is scheduled to be installed 9/25/2013. 2. Upon review by the Director of Plant Operations, the Campus Support for Plant Operations and the Executive Director, no other concerns were noted regarding this alleged Life Safety Code Standard. 3. The deficiency was evaluated related to system, education and compliance. The correction dated above was communicated to all campus managers. Shift supervisors and mangers were educated regarding the location of the display and the reading of the display at the time of a signal sound. 4. The Director of Plant Operations will maintain the documentation of the monitoring of the integrity of the alarm/signal. The results of these audits will be submitted to the Quality Improvement Committee for review each month. 5. Results from these audits will</p>	09/30/2013	

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	Based on an interview with the Director of Plant Operations at the time of observation, the water control valves have always been chained and padlocked in the open position. 3.1-19(b)		be reported to the QI (Quality Improvement) Committee. Audits will be conducted on a regular basis each month. These audits will continue as stated, or until the QI committee determines otherwise due to the outcome of the audits.		

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K010144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to provide the complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.1.1.8 requires the generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. This deficient practice affects all occupants</p> <p>Findings include:</p> <p>Based on review of the "Emergency Generator Weekly Load Test" log with the Director of Plant Operations on 09/03/13 at 11:40 a.m., the weekly load test log indicated the transfer of power from the main source to the emergency generator 10+seconds for the previous calendar year. Based on interview with the Director of Plant Operations at the time of record review, he was unable to adjust the manual transfer time to 10 second or less.</p>	K010144	<p>It is the intent of The Maples at Waterford Crossing to meet the Life Safety Code Standard so that testing of the Emergency Generator will be completed weekly and exercised under load for 30 minutes each month. 1a. Paul's Generator Service was on location at the campus on 9/11/2013 to perform their annual Load Bank testing. At this time they educated the Director of Plant Operations how to perform the monthly "under load" test. This education included a return demonstration with documentation of education. ADDENDUM: See attached 1b. The monthly "under load" testing is now a part of the preventative maintenance schedule and will be recorded at time of testing. ADDENDUM: See attached 2. Upon review by the Director of Plant Operations, the Campus Support for Plant Operations and the Executive Director, no other concerns regarding this area of Life Safety Code Standard were identified. 3. The deficiency was evaluated related to system, education and compliance. The Director of Plant Operations was educated to perform "load testing" Addendum inserted: both weekly and</p>	09/16/2013			

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	3.1-19(b)		monthly to assure operating properly in that the emergency generator will have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power.ADDENDUM: see attached4. The Director of Plant Operations will place the task of monthly "load testing" of the Emergency Generator his preventative maintenance schedule to assure it is working safely and properly. The results of these audits will be submitted to the Quality Improvement Committee for review each month. 5. Results from these audits will be reported to the QI (Quality Improvement) Committeee. Audits will be conducted on a regular basis each month. These audits will continue as stated, or until the QI committee determines otherwise due to the outcome of the audits.		