

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  05/20/2015
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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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K 000  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: 05/20/15</p> <p>Facility Number: 000106 Provider Number: 155199 AIM Number: 100266390</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, spaces open to the corridors and battery powered smoke detectors in resident rooms. The facility has a capacity of 106 and had a census of 105 at the time of this survey.</p>	K 000	<p>June 4th 2015 Dear Kim Rhoades, Please find the attached Plan of Corrections for the Life Safety Code Survey ID #JRU721 performed on May 20th, 2015. 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.</p> <p>Sincerely, Zach Krumwied, HFA Executive Director Maple Park Village</p> <p>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>	

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 025 SS=E Bldg. 01	<p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered except for two detached storage buildings which were not sprinklered.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 smoke barrier walls observed was protected to maintain the one half hour fire resistance rating of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire be protected, so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 44 residents on 200</p>	K 025	<p>1. No residents were identified as being affected. 2. There were no residents affected. However 44 residents on the 200 hall, visitors, and staff had the potential to be affected. The hall 200 center smoke barrier wall next to Nursing station II had the foam insulation removed and was sealed with an appropriate fire rated caulk to ensure at least a one half hour fire resistance rating. 3. All smoke barriers were checked and proper smoke resistance is maintained. Any new construction will be inspected by the Maintenance director to ensure compliance. 4. Smoke barriers will be</p>	06/04/2015

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K 038 SS=E Bldg. 01	<p>hall north and south as well as visitors and staff if smoke from a fire were to infiltrate the protective barrier wall.</p> <p>Findings include:</p> <p>Based on observation on 05/20/15 at 2:50 p.m. with the Maintenance Supervisor, the 200 hall center smoke barrier wall next to Nursing station II used foam insulation along the top and bottom of the east side of the wall as a fire rated material and no documentation was available for review to verify the fire rating of the foam used. Based on interview on 05/20/15 at 2:59 p.m. with the Maintenance Supervisor, it was acknowledged the aforementioned smoke barrier wall used an insulating foam material and could not verify its fire rating.</p> <p>3.1-19(b)</p> <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. 19.2.1 Based on observation and interview, the facility failed to ensure the means of egress through 2 of 2 delayed egress locks met all conditions of LSC 7.2.1.6.1 so it would be readily accessible for all</p>	K 038	<p>checked by the Maintenance Director after work is completed by all vendors and facility staff to ensure compliance.</p> <p>1. No residents were identified as being affected. 2. There were no residents affected. However 44 residents on hall 200, 32 residents on hall 300, visitors, and staff had the potential to be affected. The exit doors leading</p>	06/04/2015

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	<p>residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that: (a) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6. (b) The doors unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking</p>		<p>out of hall 200 east and hall 300 east had the delayed egress locking function removed. The doors were ensured to unlock upon actuation of an approved, supervised automatic sprinkler system installed with accordance with section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6. (b) The doors unlock upon loss of power controlling the lock or locking mechanism. 3. All exits were confirmed to be arranged so that exits are readily accessible at all times. 4. Exits will be checked once a month by the Maintenance Director to ensure compliance.</p>	

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	<p>shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS This deficient practice could affect 44 residents on 200 hall north and south and 32 residents on 300 hall north and south as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observations on 05/20/15 during the tour between 1:15 p.m. to 2:10 p.m. with the Maintenance Supervisor the exit doors leading out of 200 hall east and 300 hall east were provided with delayed egress locks, but the exit doors were not provided with signage stating the door could be opened in 15 seconds by pushing on the door. Based on interview concurrent with the observations, it was acknowledged by the Maintenance Supervisor the aforementioned exit doors were not provided with required signage.</p>			

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K 045 SS=E Bldg. 01	<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 16 residents on 200 south halls as well as staff and visitors if the facility 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 05/20/15 at 1:45 p.m. with the Maintenance Supervisor there was an exit light on generator back up located outside 300 hall south which had only a single bulb in the light fixture. Based on interview on 05/20/15 at 1:50 p.m. it was acknowledged by the</p>	K 045	<p>1. There were no residents identified as being affected. 2. There were no residents affected. However, 16 residents on hall 200 south as well as staff and visitors had the possibility to be affected if the facility were required to evacuate and the single bulb outside failed leaving the area in darkness. The exit light located outside hall 300 south was replaced with a dual bulb lighting fixture so that a failure of any single bulb would not leave the area in darkness. 3. All exit means of egress were inspected to ensure that proper lighting fixtures were present in order to prevent the failure of a single lighting fixture from leaving the area in darkness. All exit means of egress lighting fixtures will be inspected by the Maintenance Director once weekly to ensure compliance. Results of the inspection will be reported to the ED for monitoring and follow-up</p>	06/04/2015			

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	Maintenance Supervisor the outside light providing illumination for the exit discharge out of the 300 hall south exit was equipped with only a single bulb light fixture.  3.1-19(b)				