

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 05/28/2013
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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: 05/28/13</p> <p>Facility Number: 000106 Provider Number: 155199 AIM Number: 100266390</p> <p>Surveyor: Mark Caraher, 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 fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all 56</p>	K010000		

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>resident sleeping rooms. The facility has a capacity of 106 and had a census of 102 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. The facility has two detached storage buildings providing facility services which are not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/03/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010025 SS=E	<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>1. Based on observation and interview, the facility failed to ensure openings through 1 of 5 smoke barriers walls were protected to maintain the smoke resistance of each smoke barrier. This deficient practice could affect 32 residents, staff or visitors in the Moving Forward Dining Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 10:45 a.m. to 1:50 p.m. on 05/28/13, the smoke barrier wall in the attic above the corridor door set in the breezeway by the Moving Forward Dining Room had a four foot by two foot hole in the wall through which twenty cables and one, six inch in diameter sprinkler pipe passed through the opening. Based on interview at the time of observation, the Maintenance</p>	K010025	<p>1. No residents were identified as being affected. 2. There were no residents affected. However 32 residents on the moving forward hall and dining room had the potential to be affected. The four foot by two foot hole in the smoke barrier wall above the breezeway by the moving forward dining room was sealed and in order to maintain smoke resistance. The ceiling tile with an eight inch by twelve inch section missing was replaced in order to restore the smoke barrier. 3. All smoke barriers were checked and proper smoke resistance is maintained. 4. Smoke barriers will be checked by the Maintenance Director after work is completed by all vendors and facility staff to ensure compliance.</p>	06/21/2013	

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	<p>Supervisor acknowledged the aforementioned opening failed to maintain the smoke resistance of the smoke barrier wall in the attic above the corridor door set in the breezeway by the Moving Forward Dining Room.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure ensure 1 of 1 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect 24 residents, staff and visitors in the vicinity of the Hall 2 water softener room inside the soiled utility room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 10:45 a.m. to 1:50 p.m. on 05/28/13, an eight inch by twelve inch section of ceiling tile was missing in the Hall 2 water softener room inside the soiled utility room. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned location had a section of ceiling tile missing.</p> <p>3.1-19(b)</p>			

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K010027 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 5 sets of smoke barrier doors would close to form a smoke resistant barrier. Centers for Medicare & Medicaid Services (CMS) requires sets of smoke barrier doors which swing in the same direction and equipped with an astragal to have a coordinator to ensure the door which must close first always closes first. This deficient practice could affect 24 residents staff and visitors in vicinity of the smoke barrier doors by the Hall 2 Nurse's Station.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 10:45 a.m. to 1:50 p.m. on 05/28/13, the set of smoke barrier doors in the corridor near the Hall 2 Nurse's Station swing in the same</p>	K010027	<p>1. No residents were identified as being affected. 2. There were no residents affected. However 24 residents within the vicinity of the smoke barrier had the potential to be affected. The smoke barrier door set in the corridor near the hall 200 nurse's station was repaired in order to ensure that the smoke barrier doors close completely to form a smoke resistant barrier. 3. All smoke barrier doors were inspected to ensure that the closed completely and formed a smoke resistant barrier. 4. Smoke barrier doors will be checked once a month by the Maintenance Director to ensure compliance.</p>	06/21/2013			

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	<p>direction, are equipped with an astragal and a door closing coordinator but the door closing coordinator did not function when the smoke barrier door set was closed three times to ensure the door equipped with an astragal closes last and forms a smoke resistant barrier. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned smoke barrier door set did not close completely because the door closing coordinator was not functioning to ensure the door equipped with an astragal closes last and forms a smoke resistant barrier.</p> <p>3.1-19(b)</p>			

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K010029 SS=E	<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 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 2 of 11 doors serving hazardous areas such as storage rooms greater than fifty square feet in size and used to store combustible materials are provided with self closing devices to close and latch each door into the door frame. This deficient practice could affect 40 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during a tour of the facility from 10:45 a.m. to 1:50 p.m. on 05/28/13, the access door to the Activities storage room which measured 100 square feet in area and was being used to store boxes of toilet paper, napkins and pillows was not equipped with a self closing device and the access door to the Linen Room by Room 301</p>	K010029	<p>1. No residents were identified as being affected 2. There were no residents affected. However, 40 residents within the vicinity of the doors serving hazardous areas had the potential to be affected. The access door to the activities storage was equipped with a self closing device. The access door to the linen room located next to room 301 was equipped with a self closing device. 3. All doors that serve hazardous areas were inspected and ensured to have self closing devices to close and latch each door into frame. 4. All doors that serve hazardous areas will be inspected by the Maintenance director monthly to ensure that they have a self closing device to close and latch each door into frame.</p>	06/21/2013	

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	<p>which measured 80 square feet and was being used to store boxes of exam gloves, diapers, pillows and sheets was not equipped with a self closing device. Based on interview at the time of the observations, the Maintenance Supervisor acknowledged the aforementioned hazardous areas access doors were each not equipped with a self closing device to close and latch the door into the door frame.</p> <p>3.1-19(b)</p>			

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K010045 SS=E	<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 lighting for 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. This deficient practice could affect 32 residents, staff and visitors if needing to exit the facility from the breezeway south exit.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 10:45 a.m. to 1:50 p.m. on 05/28/13, the exit means of egress from the breezeway south exit is equipped with one light fixture with one bulb.</p> <p>Based on interview at the time of observation, the Maintenance Supervisor acknowledged only one light fixture with one bulb was provided at the breezeway south exit.</p> <p>3.1-19(b)</p>	K010045	<p>1. There were no residents identified as being affected. 2. There were no residents affected. However, 32 residents that may need to use the exit from the south breezeway exit had the potential to be affected. The light fixture located at the exit means of egress from the breezeway south was replaced with a new fixture ensuring that the failure of a single light fixture will 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. 4. All exit means of egress lighting fixtures will be inspected by the Maintenance Director once weekly to ensure compliance.</p>	06/21/2013			

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K010062 SS=E	<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 and interview, the facility failed to ensure 5 of over 100 sprinkler heads in the facility were maintained. NFPA 13, Standard for the Installation of Sprinkler Systems, Section 3-2.7.2 states escutcheon plates used with a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly. This deficient practice could affect 44 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during a tour of the facility from 10:45 a.m. to 1:50 p.m. on 05/28/13, the following sprinkler head locations each had a missing escutcheon plate which left a two inch opening in the ceiling:</p> <ul style="list-style-type: none"> a. Director of Nursing's office. b. Hall 2 water softener room inside the soiled utility room. c. storage room by Room 215. d. Room 215. e. Hall 2 Conference Room storage room. <p>Based on interview at the time of the observations, the Maintenance Supervisor</p>	K010062	<p>1. No residents were identified as being affected. 2. There were no residents affected. However, 44 residents that reside within distance of the missing escutcheons had the potential to be affected. The missing escutcheons noted in the areas of: the director of nursing office, the Hall 2 soiled utility room, the storage room by room 215, room 215, and hall 2 conference room were replaced.</p> <p>3. All sprinkler heads were inspected to ensure that escutcheons were present and complaint. Escutcheons were replaced if needed. 4. All sprinkler heads will be inspected monthly by the Maintenance Director to ensure compliance.</p>	06/21/2013

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	<p>acknowledged each of the aforementioned sprinkler head locations had a missing escutcheon plate which left a two inch opening in the ceiling.</p> <p>3.1-19(b)</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 2 of 2 extension cords including power strips were not used as a substitute for fixed wiring. 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 20 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during a tour of the facility from 10:45 a.m. to 1:50 p.m. on 05/28/13, two refrigerators were observed plugged into a power strip in the Hall 2 Nurse's Station Med Room and a microwave oven was observed plugged into a power strip in the Activities Room. Based on interview at the time of the observations, the Maintenance Supervisor acknowledged power strips were used as a substitute for fixed wiring at the aforementioned locations.</p> <p>3.1-19(b)</p>	K010147	<p>1. No Residents were identified as being affected. 2. There were no residents affected. However, 20 residents had the potential to be affected. The two refrigerators located in the hall 2 med room and the microwave located in the activity room were plugged directly into fixed wiring. The power strips were removed to prevent further improper use.</p> <p>3. The facility was inspected to ensure that power strips, flexible cords, and cables were not in use as a substitute for fixed wiring.</p> <p>4. The Maintenance Director will perform random facility audits weekly to ensure compliance.</p>	06/21/2013			

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