

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 07/09/2014
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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: 07/09/14</p> <p>Facility Number: 011150 Provider Number: 155760 AIM Number: 200831020</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Maples at Waterford Crossing Health Campus 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 smoke detection in the corridors, in spaces open to the corridors and hard wired smoke detectors in all the</p>	K010000	<p>The preparation or execution of this plan of correction does not constitute admission or agreement of provider of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Life Safety Code recertification and State Licensure Survey on July 9, 2014. Please accept this Plan of Correction as The Maples at Waterford Crossing's credible allegation of compliance effective July 22, 2014. The Maples at Waterford Crossing respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</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>resident rooms. The facility has a capacity of 88 and had a census of 61 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.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/17/14.</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 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 Based on observation and interview, the facility failed to ensure 1 of 3 doors leading into hazardous areas such as rooms with combustible items was provided with a self closing device which</p>	K010029	<p>1. Housekeeping storage room door was not equipped with self closing device. Director of Plant Operations added self closing device to housekeeping storage room door on</p>	07/22/2014			

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K010038 SS=B	<p>would cause the door to automatically close and latch into the door frame. This deficient practice could affect 7 residents observed in the adjacent dining room as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 07/09/14 at 1:57 p.m. with the Maintenance Supervisor, the Housekeeping storage room which was greater than fifty square feet in size located on Service hall had twenty cardboard boxes inside and the door was not equipped with a closing device. Based on interview on 07/09/14 concurrent with the observation with the Maintenance Supervisor, it was acknowledged the aforementioned corridor door would not self close and latch into the door frame.</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. 18.2.1 Based on observation and interview, the facility failed to ensure exit access was</p>	K010038	<p>7/10/14. 2. This alleged deficient practice has the potential to affect all residents. 3. All other applicable doors reviewed to ensure there are means suitable for keeping door closed. Director of Plant Operations (DPO) or designee will review at least monthly on preventative maintenance schedule the self closing feature of doors. 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> <p>1. Corridor door leading into</p>	07/22/2014			

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K010068 SS=E	<p>arranged so 1 of 4 exit access doors on Administrative hall was not equipped with 2 locking devices on the door. Section 18.2.2.2.5 states means of egress are permitted to be locked, but only one locking device shall be permitted on each door. This deficient practice could affect 9 residents on 100 hall which is adjacent to the Administrative hall as well as visitors and staff in the facility.</p> <p>Findings include:</p> <p>Based on observation on 07/09/14 at 1:33 p.m. with the Maintenance Supervisor, the corridor door leading into the Administrator's office had a door knob lock and a deadbolt lock on the door. Based on interview on 07/09/14 at 1:34 p.m., it was acknowledged by the Maintenance Supervisor there were two locking devices on the Administrator's office corridor door.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 18.5.2.2</p>		<p>Administrator's office had door knob lock and deadbolt lock on the door. Director of Plant Operations removed deadbolt lock on Administrator's office door on 7/10/14. 2. This alleged deficient practice has the potential to affect all residents. 3. All other applicable doors reviewed to ensure . Director of Plant Operations (DPO) or designee will review at least monthly on preventative maintenance schedule that no means of egress have more than one locking device on door. 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>	

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	<p>Based on observation and interview, the facility failed to ensure 1 of 1 ventless gas fireplaces was connected to a chimney or vent and installed in accordance with Exception No. 2 to LSC Section 18.5.2.2. Exception No. 2 states the fireplace shall be equipped with a fireplace enclosure guaranteed against breakage up to a temperature of 650 degrees Fahrenheit and constructed of heat tempered glass or other approved material. In addition, LSC 9.2.2 states ventilating or heat producing equipment shall be in accordance with NFPA 54, National Fuel Gas Code, 1999 Edition. NFPA 54 defines a decorative appliance for installation in a vented fireplace as a self contained, freestanding, fuel-gas burning appliance designed for installation only in a vented fireplace and whose primary function lies in the aesthetic effect of the flame. Section 6.6.2 states a decorative appliance for installation in a vented fireplace shall be installed only in a vented fireplace having a working chimney flue and constructed of noncombustible materials. This deficient practice could affect 5 residents as well as staff and visitors in the Front lounge reception area.</p> <p>Findings include:</p> <p>Based on observation on 07/09/14 at 1:40</p>	K010068	<p>The gas fireplace located in front lounge reception area is not connected to a chimney or vent. The gas line to fire place was completely disconnected on 7/10/14 which renders fireplace inoperable. 2. This alleged deficient practice has the potential to affect all residents. 3. Director of Plant Operations (DPO) or designee will verify gas line disconnected at least monthly on preventative maintenance schedule. 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>	07/22/2014

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	<p>p.m. with the Maintenance Supervisor, the Front lounge reception area has a self contained natural gas fired fireplace which was not connected to a chimney or vent. The front opening of the fireplace was covered with glass for viewing the flames. The gas fueled fireplace was not turned on at this time, however, based on interview concurrent with the observation, the Maintenance Supervisor acknowledged the gas fueled fireplace is used during the winter months and was not connected to a chimney or vent.</p> <p>3.1-19(b)</p>				