

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155766	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/16/2013
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NAME OF PROVIDER OR SUPPLIER MAPLE MANOR CHRISTIAN HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 643 W UTICA ST SELLERSBURG, IN 47172
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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: 08/16/13</p> <p>Facility Number: 000563 Provider Number: 155766 AIM Number: 100267610</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Maple Manor Christian Home Inc. 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) and 410 IAC 16.2. The original building was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility with a basement was determined to be of Type V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection on all levels including the basement, in the corridors, in spaces</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>open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 57 and had a census of 52 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/21/13.</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>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers and 2 of 62 room wall smoke barriers were maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 24 residents who reside on the 200 Hall and 13 residents who reside on the 100 Hall.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 08/16/13 from 9:30 a.m. to 1:15 p.m., the Main Hall soiled linen room for the 100 Hall and the 200 Hall each had a twelve inch by sixteen inch area of concrete missing on the south walls where new plumbing was visible. Furthermore, the plumbing was installed through the center of the</p>	K010025	K025 The deficient practice of ceiling smoke barriers and the smoke barriers that could affect 24 residents on 200 hall and 13 residents on 100. The deficient practice of the ceiling smoke barriers was resolved on August 19, 2013. The wall smoke barriers were repaired on August 28, 2013. The maintenance department will monitor areas in the ceiling and wall to ensure that the smoke barriers are maintained using the attached Maintenance Gap Check form.	09/13/2013			

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	<p>concrete blocks from the attic to the rooms, which created a smoke barrier penetration between the attic and both soiled linen rooms. Based on an interview with the maintenance supervisor on 08/16/13 at 11:20 a.m., the two soiled linen rooms had new plumbing installed over the past few months and the walls are still under repair. This was acknowledged by the administrator at the exit conference on 08/16/13 at 1:15 p.m.</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 the corridor door to 1 of 7 hazardous areas, such as a soiled linen room, was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 24 residents who reside on the 200 Hall near the soiled linen room.</p> <p>Findings include:</p> <p>Based on observation on 08/16/13 at 12:20 p.m. with the maintenance supervisor, the 200 Hall soiled linen room door lacked a self closing device. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 08/16/13 at 1:15 p.m.</p> <p>3.1-19(b)</p>	K010029	K029 The deficient practice of not having a self closing device on the door to the soiled linen room on 200 hall that could have affected 24 residents on 200 hall. This deficient will be resolved by September 13, 2013. The maintenance department will monitor the door closing devices each month to ensure that they are in working condition using the attached Self Closing Devices form.	09/13/2013			

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	<p>corridors, in spaces open to the corridors, and battery operated smoke detectors in all resident rooms. The facility has a capacity of 57 and had a census of 52 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.</p>			