STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155766	A. BUILDING 01 B. WING	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

(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
K 0000 Bldg. 01	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). Survey Date: 10/05/16 Facility Number: 000563 Provider Number: 155766 AIM Number: 100267610 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. This one story facility with a basement was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection on all levels including the basement, the corridors, spaces open to the corridors, hard wired smoke detectors in resident rooms 300, 301,	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	302, 303, 304, 305, 306. 307. 308 and battery operated smoke detectors in the remaining resident sleeping rooms. The facility has a capacity of 57 and had a census of 47 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 10/05/16 - DA			
K 0052 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, Based on record review and interview, the facility failed to ensure 3 of 36 photoelectric smoke detectors and 1 of 9 combination audio/visual devices were replaced or repaired after annual maintenance was conducted on the fire alarm system components in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the	K 0052	The deficient practice of 3 smoke detectors not being in working order was corrected by Koorsen Fire and Security on December 10, 2015. I have attached the work order from Koorsen Fire and Security.	10/06/2016

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	schedules in Chapter 7 or more often if required by the authority having jurisdiction. Table 7-3.2 shall apply. Table 7-3.2 "Testing Frequencies" requires alarm initiating devices, alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the facility's most recent annual Koorsen Fire Alarm System Inspection and Testing Report on 10/04/16 at 9:10 a.m. with the maintenance supervisor, the annual report dated 12/07/15 indicated the photoelectric smoke detector outside room 104, the photoelectric smoke detector outside room 107, the photoelectric smoke detector outside room 101, and the combination visual strobe/horn outside room 109 each failed the annual functional test. Based on a review of Koorsen Fire Alarm System Inspection and Testing Reports with the maintenance supervisor at the time of record review dating from 12/07/15 to 01/11/12, there was no records available to indicate the three photoelectric smoke detectors and the combination visual/strobe were repaired or replaced after the 12/07/15 annual inspection was			

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	conducted. This was verified by the maintenance supervisor at the time of record review and acknowledged by the maintenance supervisor at the exit conference on 10/05/15 at 12:00 p.m. 3.1-19(b)			
K 0067 SS=B Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 Based on observation and interview, the facility failed to ensure 3 of 3 fire damper were provided four year maintenance in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects staff only who work in the Service Hall laundry room.	K 0067	The deficient practice of not ensuring that the 3 fire damper were provided four year maintenance was corrected on October 6, 2016. The Maintenance department will check and maintain the fire dampers every four years according to the NFPA. The administrator or his designee will oversee the Maintenance department to make sure that the fire dampers are checked and lubricated as necessary.	10/06/2016

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	Findings include: Based on observations on 10/04/16 at 11:10 a.m. with the maintenance supervisor, the laundry room supply air ducts each had a fusible link fire damper. Based on an interview with the maintenance supervisor on 10/04/16 at 11:10 a.m. when asked if a four year maintenance inspection had been conducted on the three fire dampers, the maintenance supervisor indicated there was no fire damper inspection conducted on the three fire dampers in the laundry room supply air ducts. The lack of a four year fire damper maintenance inspection on the three laundry room fire dampers was verified by the maintenance supervisor at the time of observation and acknowledged by the maintenance supervisor at the exit conference on 10/04/16 at 12:00 p.m. 3.1-19(b)			
K 0144 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6			

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	(NFPA 110) Based on record review and interview, the facility failed to document the transfer time between normal power and emergency power for 12 of the past 12 monthly load tests over the past year. NFPA 99, the Standard for Health Care Facilities, 3-4.1.1.8 requires the generator set shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency systems within 10 seconds after loss of normal power. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the Monthly Load Test Log with the maintenance supervisor on 10/05/16 at 11:50 a.m., the past twelve monthly load tests conducted lacked the transfer time between normal power and emergency power. Based on an interview with the maintenance supervisor on 10/05/16 at 11:55 a.m., the maintenance supervisor stated it was not known the transfer time was required to be listed on the monthly load test log. The lack of the transfer time between normal power and emergency power listed on the Monthly Load Test Log was acknowledged by the maintenance supervisor at the exit conference on	K 0144	The deficient practice of not documenting the time between normal power and emergency power for the monthly load tests over the last year has been corrected. The Maintenance department log the time it takes for the generator to go from normal power to emergency power. The Administrator or his designee will monitor the maintenance department to ensure that the time is checked each month.	10/10/2016

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	10/05/16 at 12:00 p.m. 3.1-19(b)			
K 0000 Bldg. 04	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). Survey Date: 10/05/16 Facility Number: 000563 Provider Number: 155766 AIM Number: 100267610 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 2011 Visitor Room addition was surveyed with Chapter 18, New Health Care Occupancies. This 2011 Visitor Room addition to the one story facility with a basement was determined to be of Type V (111) construction and fully sprinkled. The	K 0000		

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	facility has a fire alarm system with smoke detection on all levels including the basement, the corridors, spaces open to the corridors, hard wired smoke detectors in resident rooms 300, 301, 302, 303, 304, 305, 306, 307, 308 and battery operated smoke detectors in the remaining resident rooms. The facility has a capacity of 57 and had a census of 47 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.			
K 0144 SS=F Bldg. 04	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) Based on record review and interview, the facility failed to document the transfer time between normal power and emergency power for 12 of the past 12 monthly load tests over the past year. NFPA 99, the Standard for Health Care Facilities, 3-4.1.1.8 requires the generator set shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency systems within 10 seconds after loss of normal power. This deficient practice could	K 0144	The deficient practice of not documenting the time between normal power and emergency power for the monthly load tests over the last year has been corrected. The Maintenance department log the time it takes for the generator to go from normal power to emergency power. The Administrator or his designee will monitor the maintenance department to ensure that the time is checked each month.	10/10/2016

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	affect all residents, staff and visitors who use the 2011 Visitor Room Addition. Findings include: Based on review of the Monthly Load Test Log with the maintenance supervisor on 10/05/16 at 11:50 a.m., the past twelve monthly load tests conducted lacked the transfer time between normal power and emergency power. Based on an interview with the maintenance supervisor on 10/05/16 at 11:55 a.m., the maintenance supervisor stated it was not known the transfer time was required to be listed on the monthly load test log. The lack of the transfer time between normal power and emergency power listed on the Monthly Load Test Log was acknowledged by the maintenance supervisor at the exit conference on 10/05/16 at 12:00 p.m. 3.1-19(b)			