STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155766	A. BUILDING -- B. WING	11/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/29/22 Facility Number: 000563 Provider Number: 155766 AIM Number: 100267610 At this Emergency Preparedness survey, Maple Manor Christian Home Inc. was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 57 certified beds. At the time of the survey, the census was 42. Quality Review completed on 11/30/22	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/29/22 Facility Number: 000563 Provider Number: 155766 AIM Number: 100267610 At this Life Safety Code survey, Maple Manor	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Steven Cunningham	Administrator	12/19/2022

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Christian Home Inc was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. 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, 302, 303, 304, 305, 306, 307, 308, plus battery operated smoke alarms in the remaining resident sleeping rooms. The facility has a capacity of 57 and had a census of 42 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 11/30/22			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 5 corridor means of egress were continuously maintained free of	K 0211	The deficient practice of storing recliners and a side table has been corrected by moving the	11/30/2022

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	obstructions. This deficient practice could affect at least 15 residents, as well as staff and visitors in the 200 hall. Findings include: Based on observations on 11/29/22 between 12:00 p.m. and 2:00 p.m. during a tour of the facility with the Administrator and House Keeping/Maintenance Assistant, there were three recliners and a side table stored in the 200 egress corridor near the exit door. Based on interview at the time of observation, the Administrator said at least one of the recliners had been there for about six months, he further said they were waiting on a family member of a former resident to pick up the recliner. This finding was reviewed with the Administrator and House Keeping/Maintenance Assistant during the exit conference. 3.1-19(b)		ones that were in usable condition into rooms that can be used by a resident. The ones that were not usable were thrown away. The recliners and side table were removed from the hallway on November 30, 2022. The Administrator and/or the Maintenance Department will monitor the hallways to ensure that nothing will be stored in the hallways from this time forward. See attached excel weekly maintenance hall check list spread sheet.	
K 0300 SS=E Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to replace battery operated smoke alarms installed in 33 of 33 resident sleeping rooms in the 100 and 200 halls in accordance with NFPA 72. NFPA 72, 2010 Edition, Section 14.4.8.1 states unless otherwise recommended by the	K 0300	The deficient practice of not replacing smoke detectors that were outdated has been corrected by the Maintenance Department after buying new ones and replacing the battery-operated	12/13/2022

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	manufacturer's published instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect 30 of 42 residents, staff and visitors. Findings include: Based on observation on 11/29/22 at 11:00 a.m. while performing record review, the Maintenance Supervisor brought in a few resident room battery operated smoke alarms. All resident room battery operated smoke alarms had manufactured dates of 01/10/11 or prior. The smoke alarms observed all stated "replace the unit within 10 years of installation date". The Maintenance Supervisor said all the smoke alarms in resident rooms were installed prior to 2012 and agreed all resident room smoke alarms should be replaced. This finding was reviewed with the Administrator and House Keeping/Maintenance Assistant during the exit conference. 3.1-19(b)		smoke detectors on Halls 100 and 200. The new smoke detectors were installed on December 13, 2022. The Administrator and/or his designee will ensure that in 2032 new smoke detectors will be purchased and replace the 10-year smoke detectors on Halls 100 and 200.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2			

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	* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure the cook tops in 2 of 2 rooms was shut off at the switch when not in use. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect all residents while in the Physical Therapy Room and Activity Room.	K 0324	The deficient practice of not deactivating 2 cooktop stoves has been corrected. The one cooktop stove in the Physical Therapy room was removed and placed in the Activity Room. The Activity Room cooktop stove was then discarded. On December 1, 2022, Spicer Electric installed a disconnect breaker in the Activity Room that can deactivate that cooktop stove when not in use. The power outlet for the cooktop stove in the Physical Therapy room was disconnected at the breaker box by Spicer Electric making that plug inactive. The Activity Director and/or her designee will ensure that the breaker on the cooktop stove will be off when it is not in use.	12/01/2022

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	Findings include: Based on observations on 11/29/22 between 12:00 p.m. and 2:00 p.m. during a tour of the facility with the Administrator and House Keeping/Maintenance Assistant, there were cooktop stoves in the Physical Therapy and Activity rooms. When checked, and not in use, these stove top appliances were not deactivated from the individual cooktop power sources. Based on interview at the time of observation, the Administrator confirmed both cooktop stoves were not deactivated when not in use. This finding was reviewed with the Administrator and House Keeping/Maintenance Assistant during the exit conference. 3.1-19(b)			
K 0331 SS=E Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). Based on observation and interview, the facility failed to ensure 1 of 5 smoke compartments was provided with a complete interior finish with a flame spread rating of Class A or Class B for a sprinklered facility. LSC 3.3.90.4 defines interior wall finish as the interior finish of columns, fixed	K 0331	The deficient practice of not having a flame spread rated panel on the attic access in the 200 hall clean linen closet has been corrected. On November 30, 2022, the Maintenance Department installed	11/30/2022

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	or movable walls, and fixed or movable partitions. A.3.3.90.2 states interior finish is not intended to apply to surfaces within spaces such as those that are concealed or inaccessible. This deficient practice could affect up to 15 residents, staff, and visitors while in the same smoke compartment. Findings include: Based on observation on 11/29/22 between 12:00 p.m. and 2:00 p.m. during a tour of the facility with the Administrator and House Keeping/Maintenance Assistant, there was a two foot by two foot plywood attic access panel in the 200 hall Linen room. This was acknowledged by the Administrator at the time of observation, furthermore, the House Keeping/Maintenance Assistant said the plywood attic access panel did not have a flame spread rating as far as he knew. This finding was reviewed with the Administrator and House Keeping/Maintenance Assistant during the exit conference. 3.1-19(b)		a two foot by two foot piece of drywall on the attic access panel in order to comply with the regulation. The Administrator and/or his designee will ensure that all attic accesses will meet the requirements in the future.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1. Based on record review and interview, the	K 0345	The deficient practice of not	01/03/2023

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	facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 11/29/22 between 9:00 a.m. and 12:00 p.m. with the Administrator, Maintenance Supervisor, and House Keeping/Maintenance Supervisor present, there was documentation provided regarding an annual fire alarm system inspection dated 07/26/22 by the facility's fire alarm inspection vendor, however, there was no semi-annual visual inspection documentation provided prior to the annual inspection either by the vendor or in-house maintenance staff. Based on interview at the time of record review, the Administrator said a semi-annual visual inspection of the fire alarm system's devices has never been performed. This finding was reviewed with the Administrator and House Keeping/Maintenance Assistant during the exit conference.		performing visual inspections of the fire system will be corrected beginning in January 2023 which will be the time for the semi-annual inspection. The Administrator and/or his designee will ensure that every January the semi-annual visual inspection will be conducted. See attached fire alarm annual visual check spreadsheet.	

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	3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm system was continuously in proper operating condition. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 11/29/22 between 9:00 a.m. and 12:00 p.m. with the Administrator, Maintenance Supervisor, and House Keeping/Maintenance Assistant present, the annual fire alarm system report dated 07/26/22 indicated the Pull Station at "Front 200 Hall" Failed in the comments section. It said "Critical, Hinge broke, fire lite, BG12LX". Based on interview at the time of record review, the Administrator said, after calling the facility's vendor, the pull station has not been repaired or replaced. This finding was reviewed with the Administrator and House Keeping/Maintenance Assistant during the exit conference. 3.1-19(b)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.			

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	a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested during 2 of 4 quarters for 1 of 1 sprinkler system. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility.	K 0353	The deficient practice of the sprinkler system not being tested quarterly has been resolved on November 29, 2022. The Administrator while on a phone call to Ryan Fireprotection, Inc. set up the quarterly sprinkler system inspections for the year 2023. The inspections are scheduled for January, April, July, and October in 2023 and for the years following. The Administrator and/or his designee will be responsible in making sure that Ryan Fireprotection comes out to do the inspections each of those months. The deficient practice of failing to ensure that the escutcheon in the Physical Therapy room was in place. This deficient practice was resolved on November 30, 2022. The Maintenance Department replaced the escutcheon on the one sprinkler head in the Physical Therapy room securing the gap the was caused by the missing escutcheon. The Administrator and/or the Maintenance Department will ensure that the	11/29/2022

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	Findings include: Based on review of the quarterly sprinkler system inspection records on 11/29/22 between 9:00 a.m. and 2:00 p.m. with the Administrator, Maintenance Supervisor, and House Keeping/Maintenance Assistant present, there were no quarterly sprinkler system inspection reports available for the first quarter (January, February, and March), and third quarter (July, August, and September) of 2022. Based on interview at the time of record review, the Administrator acknowledged there was no written documentation available to show the sprinkler system had been inspected during the first and third quarters of 2022. This finding was reviewed with the Administrator and House Keeping/Maintenance Assistant during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the sprinkler head in 1 of 5 sprinklered smoke compartments was maintained to allow the sprinkler head to function to it's full capability. This deficient practice could affect residents and staff in the Physical Therapy room. Findings include: Based on observations on 11/29/22 between 12:00 p.m. and 2:00 p.m. during a tour of the facility with the Administrator and House Keeping/Maintenance Assistant, one sprinkler in the Physical Therapy room was missing its escutcheon leaving a one half inch gap around the sprinkler pipe to the attic space. Based on interview at the time of observation, the		escutcheons are all in place with a visual inspection at least monthly. Those that are missing will be replaced, if any and those that have slipped down will be repaired.	

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	Administrator acknowledged the missing sprinkler escutcheon in the Physical Therapy room. This finding was reviewed with the Administrator and House Keeping/Maintenance Assistant during the exit conference. 3.1-19(b)			