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	02/08/2024

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. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 12/13/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/08/24 Facility Number: 000563 Provider Number: 155766 AIM Number: 100267610 At this PSR survey to the 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 51. Quality Review completed on 02/09/24	E 0000		
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 12/13/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 02/08/24 Facility Number: 000563 Provider Number: 155766 AIM Number: 100267610	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Steven Cunningham	Administrator	02/20/2024

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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	155766	A. BUILDING 01 B. WING	02/08/2024

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

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	At this PSR survey, Maple Manor 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 partial 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 and has hard wired smoke detectors in resident rooms 300, 301, 302, 303, 304, 305, 306, 307, 308. The facility has battery operated smoke alarms in the remaining resident sleeping rooms. The facility has a capacity of 57 and had a census of 51 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 02/09/24			
K 0311 SS=F Bldg. 01	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed			

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	155766	A. BUILDING 01 B. WING	02/08/2024

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	with construction providing at least a 2-hour fire resistance rating, also check this box.			
	Based on observation and interview, the facility failed to ensure the protection of 2 of 2 former dumbwaiters was in accordance with 19.3.1. LSC 19.3.1.1 states where enclosure is provided, the construction shall have not less than a 1-hour fire resistance rating. LSC 8.3.4.2 states the fire protection rating for opening protectives shall be in accordance with Table 8.3.4.2 except as otherwise permitted in 8.3.4.3 or 8.3.4.4. Table 8.3.4.2 requires fire door assemblies in vertical shafts, including stairways, to have a 1-hour fire resistance rating. LSC 8.3.4.3 states existing fire door assemblies having a minimum ¾-hour fire protection rating shall be permitted to continue to be used in vertical openings and exit enclosures in lieu of the minimum 1-hour fire protection rating required in Table 8.3.4.2. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations with the Administrator at 12:01 p.m. and 12:04 p.m. on 02/08/24, each of the two vertical shafts extending from the basement storage room to the attic were noted in the basement storage room. The shafts were constructed of concrete blocks but had a three foot by one foot opening at the top of each shaft as observed from the attic. Red and blue plastic water lines were running through the opening at the top of each shaft. Based on interview at the time of the observations, the Administrator stated the two shafts were for former dumbwaiter locations which had been taken out of the facility a long time ago, the facility is still working on enclosing the shafts and agreed the former dumbwaiter shafts were not enclosed with	K 0311	The deficient practice of not having the top part of the dumbwaiters seal in the attic has been corrected on February 19, 2024. Maintenance sealed both holes with 2 pieces of 5/8 drywall. The holes for the water lines were sealed with fire caulk. I have included pictures of the repair.	02/19/2024

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	minimum one-hour fire-rated construction at the top of each shaft. These findings were reviewed with the Administrator during the exit conference. This deficiency was cited on 12/13/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)			